



Tanzania

Country Operational Plan (COP) 2020

Strategic Direction Summary

March 30, 2020

1.0 Goal Statement

One year ago, PEPFAR Tanzania (PEPFAR/T) was in the throes of pivoting program activities based on findings from the Tanzania HIV/AIDS Impact Survey 2016-2017 (THIS). Transforming our understanding of the HIV epidemic in Tanzania, the survey showed that only 61% of people living with HIV (PLHIV) older than age 15 knew their HIV status, indicating that finding and diagnosing PLHIV was a programmatic challenge. The THIS also indicated that the geographic areas where PEPFAR/T had been focusing, were not actually the places with the biggest treatment gap. These findings triggered a programmatic overhaul that included scaling up index testing with fidelity, intensified strategies to link clients and retain them in treatment, and a shift of national policy towards multi-month dispensing (MMD), community anti-retroviral therapy (ART), self-testing, and Pre-exposure Prophylaxis (PrEP) scale-up.

The result has been historic performance during FY19 including: a reduction in over-testing, tripling of testing yield from 2.6% in FY19 Q1 to nearly 8% in FY20 Q1; increasing index testing yield from 5% in FY18 Q1 to 28% in FY20 Q1; improving targeted provider initiated testing and counseling (PITC); unprecedented treatment growth with Tanzania's NET_NEW increasing from 138,414 in FY18 to 233,979 in FY19; and ultimately reaching 73% community viral load suppression. This, of course, has been complemented by successful prevention activities including meeting voluntary medical male circumcision (VMMC) and key and vulnerable population (KVP) program targets.

The core of PEPFAR/T's success has been using the right data to identify gaps, strategically using people – including PEPFAR staff, partner staff, government, and others – to select and tailor effective strategies to close those gaps, and ensuring that systems, including policies, are responsive so that we can continually measure progress against closing any gaps. Moving into COP20, PEPFAR/T will continue to rely on this approach to ensure success as we strive to achieve continued success in pursuit of 95-95-95 goals. This will include specific focus on continuing to rapidly accelerate ART enrollment and strengthen retention with the goal of community viral load suppression and morbidity and mortality reduction, while complementing these initiatives by preventing new infections.

In COP20, we will continue to roll out index testing with fidelity, with a continued emphasis on ensuring that services offered are of high quality, non-coercive, and confidential. Working closely with civil society to develop and roll out community-led monitoring efforts will play a key role to achieve this goal. At the same time, we will further hone our PITC screening to ensure we are testing those most at risk. Self-testing scale-up with fidelity will be rolled out nation-wide. Recency surveillance is being integrated into route HIV testing services (HTS) and will inform refinement of case finding strategies. And all efforts will be complemented by efforts to address widespread stigma and discrimination that leads to fear of testing and reduction in service quality for people living with HIV.

In the context of treatment, PEPFAR/T will build on current efforts to roll out 6-multi-month dispensing (6MMD) and complete the transition to Dolutegravir-based regimens, so that in COP20, efforts to strengthen linkage and retention efforts will continue to minimize patient loss. This will include a renewed emphasis on treatment literacy at facility and community levels. Community-ART enrollment and refills will continue for key and vulnerable populations. Finally, efforts to strengthen pediatric case finding and optimize pediatric regimens will help address this programmatic gap. Diagnostic network optimization will ensure access to viral load testing, and supply chain modernization will strengthen Tanzania's supply chain and minimize disruptions.

On the prevention front, PEPFAR/T will set the stage in the current fiscal year to start immediate PrEP scale up by May 2020 placing the team in a good position to reach COP20 targets. Continued regular engagement of the KVP Forum will ensure that KVP activities are being implemented effectively at the community level. VMMC activities will pivot to focus on older men, and innovation funding will provide the space to implement new approaches to reach this population.

Strategies alone, even the right ones, are not enough for success. Those strategies must be built on a solid foundation of political will and an enabling policy environment. Over the last two years, Tanzania has made great strides implementing policies on same-day ART initiation, multi-month scripting, and scaling up index testing among others. In COP20, the policy focus will be on scaling up PrEP and self-testing and supporting roll out of Tanzania's unique identification strategy.

Even strategies built on a strong policy foundation are not enough for rapid progress. Wise use of data, with analysis down to the site-level, is needed to rapidly accelerate progress. At the Regional Planning Meeting, the Government of Tanzania (GOT), along with the United States Government (USG), renewed their commitment to working closely together to review site-level data, to use those data for rapid action, and to continue its monthly program and policy review meetings chaired monthly by the Chief Medical Officer and quarterly by the Honorable Minister of Health or Deputy Minister. GOT and USG will continue work side-by-side throughout this process to ensure that proposed policy changes quickly roll-out at facility and patient levels.

Due to prior PEPFAR/T investments in systems strengthening, patient-level data are now available for >90% of people covered by the program and are used to track program progress and accelerate implementation of key interventions such as isoniazid preventive therapy. The USG will continue to invest in GOT staff capacity to ensure they are able to use these data effectively. The GOT and USG will build on existing site-level regional team and rapid-response strategies to optimize partner performance beyond the initial 241 sites where 50% of PEPFAR/T's clients on treatment are seen. Lower performing partners will continue to undergo intensive remediation and mentoring.

Ensuring that the strategies used continue to evolve to meet the changing needs of the epidemic, and that they are implemented well and in a person-centered manner requires broad engagement with a wide range of stakeholders. Civil society organizations (CSOs) have had an expanding role in Tanzania, and their contributions have substantially aided progress, including reach to key populations and reducing stigma. PEPFAR/T will continue this engagement with the aim of expanding their role in Tanzania. Close collaboration with United Nations Joint Program on HIV/AIDS (UNAIDS), World Health Organization (WHO), The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and other key stakeholders is also key to success.

Finally, above-site investments focus on supporting all of these priorities through human resources for health (HRH) to facilitate implementation; systems for rapid access to and use of high quality data that will facilitate immediate use of data for improvement, and foster the principle of having one unified data system for Tanzania; laboratory investments to ensure high quality testing and viral load monitoring; and institutional strengthening that will continue steps towards sustainability.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

According to THIS 2016-2017¹, the prevalence of HIV among adults aged 15-64 years in Tanzania is 5% (7% among females and 4% among males). UNAIDS Spectrum 2019 estimates approximately 1.64 million² PLHIV in Tanzania out of total population of 56,194,448³, with regional variations from 9,216 (Zanzibar) to 230,095 (Dar es Salaam)⁴. According to the THIS 2016-2017, the prevalence of viral load suppression (VLS) among HIV-positive adults aged 15-64 years in Tanzania who self-report current use of ART is 87% (89% among females and 83% among males)⁵. The prevalence of HIV among children aged 10-14 is less than 1% (0.3% among males)⁶. The prevalence of HIV among children aged 10-14 is less than 1% (0.3%) yet the proportion of children with HIV who are virally suppressed is low at 18%. The annual incidence of HIV among adults ages 15 to 64 years in Tanzania is 0.3% (0.4% among females and 0.12% among males).

While the major programmatic and system gaps are considerable, data show some areas of important progress. The Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) from 2011/2012 showed that HIV prevalence among adults aged 15-49 years was 5% [CI: 4.6-5.6] while the THIS showed an HIV prevalence of 4.7% [CI: 4.3-5.0]. Projections from the UNAIDS Spectrum 2020 model show that, the number of new HIV infections have been declining steadily over the years, from 81,793 to 80,523 between 2015 and 2016; and in 2018, it was estimated to be 72,547 while in 2019 was 65,779. Additionally, the total deaths for PLHIV has also been steadily declining, from an estimated 40,785 to 38,835 between 2015 and 2016 compared to an estimated decrease to 36,248 total deaths in 2019⁶.

THIS 2016-17 showed that only 52% of people with HIV in Tanzania self-reported knowledge of HIV status, although this increased to 61% after analysis of the antiretroviral drugs (ARV)-metabolite data. Of those who self-reported knowing their HIV status, 94% self-reported current use of ART and 87% of those on ART are virally suppressed.

Key populations (KPs) also play a critical role in HIV transmission dynamics. Studies in Dar es Salaam estimate that HIV prevalence is 36% among people who inject drugs (PWID), 26% among sex workers (SWs), and 25% for men who have sex with men (MSM).⁷ Based on program data, 98% of pregnant women had HIV testing in at least one antenatal care (ANC) visit. The national coverage of male circumcision in Tanzania has risen from a national overall average of 72% (THMIS 2012) to 80% in males aged 15 to 29 years (THIS, 2016-2017). In addition, COP20 coverage for KVP include expanding geographic and hotspot coverage of adolescent girls and young women (AGYW), female sex workers (FSW), MSM, and PWID to 30%; 90%; 85%; and 90% respectively.

THIS 2016-2017 data also showed that HIV prevalence varies by population in Tanzania. HIV prevalence is highest among females aged 40 to 44 years, at approximately 11% compared to 8.5% among males aged 40 to 44 years. According to the 2019 UNAIDS Spectrum Estimates, prevalence among adults aged 15 to 24 years is 2.9% (3.8 % among females and 1.9% among males), while prevalence among children aged 0-14 years is 0.3%. The disparity in HIV

¹ Tanzania HIV/AIDS Indicator Survey (THIS) 2016-2017

² 2020 Spectrum estimates, 2019-point estimate

³ To be cross-checked -National Bureau of Statistics (NBS) Population Projection, March 2020

⁴ 2020 Spectrum estimates

⁵ Tanzania HIV/AIDS Indicator Survey (THIS) 2016-2017

⁶ 2020 Spectrum estimates

⁷ Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014.

prevalence between males and females is highest among younger adults, with women in age groups 15-19, 20-24, 25-29, 30-34 and 35-39 years having prevalence rates that are more than double that of males in the same age groups.

The burden of HIV infection also varies geographically across Tanzania, ranging from 11% in Njombe to less than one percent (<1%) in Zanzibar. HIV prevalence also varies between urban (6%) and rural (4%) areas. Spectrum 2019 modelling estimates used THIS 2016-2017 and past survey data, sentinel surveillance data, as well as routine program data to estimate the number of PLHIV in the country. Spectrum 2019 results showed a shift of HIV burden among regions compared to COP19 Spectrum files due to the inclusion of UNAIDS Naomi model outputs which accounted for additional information, including point estimate uncertainty estimations and health seeking behavior variability for HIV-positive clients across geographical areas, in Spectrum inputs. Dar es Salaam, Kagera, Mbeya, Mwanza, and Tabora showing the highest increment of estimated number of PLHIV. Katavi, Manyara, Singida, and Kigoma, and Zanzibar showing highest decrease of the estimated number of PLHIV. In COP20, PEPFAR/T continues to prioritize HIV programming efforts on the HIV burden to better align resources with the latest epidemiologic information.

For COP20, the Spectrum 2019 national file was used to determine regional PLHIV estimates, to which the UNAIDS Spectrum 2019 District Estimates Tool was applied to distribute regional estimates down to the council level, the subnational unit level required for PEPFAR planning in Tanzania. Spectrum District Estimate Tools included routine programmatic data for ANC attendance, VL suppression, national ART prevalence data among 15-49 year-old population from COP18 implementation, as well as granular program data in order to produce council-level age disaggregated estimates for the number of PLHIV. UNAIDS Naomi Model, a new district-level HIV estimation model, was also utilized to produce more precise and accurate estimates of prevalence, ART coverage and incidence. This new model maximizes information used from auxiliary data sources (population-based surveys, geographical data, etc.) by jointly modeling HIV prevalence and ART coverage, and utilizing a model-based approach for reallocating ART patients across districts for clients seeking care outside of their districts of residence.⁸ Through the inclusion of routine program data into the Spectrum 2019 model methodology, the denominators between COP19 and COP20 were affected, particularly for regions outside of the top 10 highest burden regions for which THIS was powered.

As such, in COP20, PEPFAR/T used the Spectrum 2019 estimates in the COP20 Data Pack, but adjusted TX_CURR targets by region accordingly, to align with triangulated THIS survey data and programmatic knowledge. This approach guides the geographic breadth and scope of activities to sustain the gains of COP19 and progress in FY20.

In terms of implementation of key policies, GOT has initiated policy revisions to move Tanzania closer to epidemic control through provision of updated circulars and revised National Guidelines for the Management of HIV and AIDS (2019) after the COP19 Regional Planning Meeting in Johannesburg. This included updating same-day ART initiation from 14 days to within seven days, implementing six-month multi-month dispensing (MMD), and the release of new HIV Testing Guidelines 2019. During FY19, GoT adopted and implemented differentiated service delivery models, including six-month/multi-month/and three-month dispensing of ARVs. Currently, six-month multi-month dispensing has begun in Dar es Salaam after delays since July 2019. Additional scale-up to other regions is planned for COP20. Following FY19 shifts to

⁸ UNAIDS Reference Group on Estimates, Modelling, and Projections- Next Generation Tools for Subnational HIV Strategic Information in sub-Saharan Africa Report and Recommendations. (2019) (pp. 4–28). Glastonbury, USA.

scale-up pre-exposure prophylaxis (PrEP) for key populations and discordant couples, in COP20, the GOT has proposed to immediately scale-up PrEP nationwide. PrEP has been prioritized for groups of people who have substantial risk of acquiring HIV: serodiscordant couples, AGYWs, pregnant and breastfeeding women, MSM, transgender individuals, sex workers, and PWID. The GoT has adopted amendments of the HIV and AIDS Prevention and Control Act (HAPCA) to allow for HIV self-testing in adults and lowering the age of consent for HIV testing from 18 to 15 years (approved in November 2019). Finally, the GOT is supportive of ongoing efforts to scale-up TB preventive treatment (TPT) to more than 75 % of eligible clients on IPT. PEPFAR/T aims to achieve 100% IPT coverage of all eligible clients during COP20 by working in close collaboration with the government to ensure a reliable supply of Isoniazid to increase the number of clients enrolled in and completing IPT.

To address gaps in HRH and supply chain, PEPFAR/T shall continue to support the implementation of the task sharing policy, in conjunction with the HIV differentiated service delivery model (DSM) roll out. In COP19, PEPFAR/T focused on implementation of the task sharing policy including in-service training through distance and blended learning approaches. PEPFAR/T will work with the GOT to ensure the integration of developed tools into the existing national Human Resource for Health Information Systems (HRHIS) towards strengthening of workforce capacity, needed to reach HIV epidemic control. PEPFAR/T will also focus on designing a customized HRH cascade to guide decision making during allocation of HRH, recruitment, and retention, to complement the existing Health Systems Strengthening/HRH Monitoring, Evaluation, and Reporting (MER) indicators. This will also include a deeper analysis using the PEPFAR/T Health Worker Inventory of 2019 and other data sources to triangulate information to effectively guide HRH investment based on needs.

The major programmatic and system gaps and barriers to achieve epidemic control were assessed in 2019 using the Sustainability Index Dashboard (SID), which is discussed in more detail in section 2.4.1. The findings from the 2019 SID showed that within the four critical domains (Governance, Leadership, and Accountability; National Health System and Service Delivery; Strategic Financing and Market Openness; and Strategic Information) scores were generated for all seven of the sub-elements. Marked improvements were seen in the Governance, Leadership and Accountability domain, where 7 sub-elements scored green, while additional improvements were also observed in the Strategic Information domain.

Tanzania's gross national income (GNI) per capita in 2017 was \$936⁹, which indicates limited income to accommodate health expenditures. Tanzania's total health expenditure (THE) was 6.1% of gross domestic product (GDP) in 2015 and 11% of government spending in 2015¹⁰, less than the Abuja declaration target of 15%. These indicators show the need for more funds to provide health services in Tanzania as both government and household spending on health is relatively low.

⁹ World Bank national accounts data, 2017

¹⁰ Health Policy Project, Health financing profile Tanzania, 2016

Standard Table 2.1.1: Host Country Government Results

	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	55,890,747	100	12,104,023	22	12,250,461	22	5,475,698	10	5,406,712	10	10,954,837	20	9,699,016	17	National Population Projections, Feb 2018
HIV Prevalence (%)		4.9		0.5		0.3		2.1		0.6		Not available		Not available	THIS, 2016-2017
AIDS Deaths (per year)	25,582		2,185		2,346		1,336		1,013		7,611		11,090		SPECTRUM, 2020
# PLHIV	1,643,665		38,889		40,050		102,428		54,022		834,641		573,626		SPECTRUM, 2020
Incidence Rate (Yr.)		1.24		Not available	SPECTRUM, 2020										
New Infections (Yr.)	65,779														SPECTRUM, 2020
Annual births	2,101,519	Not available													National Population Projections, Feb 2018
% of Pregnant Women with at least one ANC visit	Not available	98	Not available	Not available			Not available	98.5			Not available	98			THIS, 2016-2017
Pregnant women needing ARV/s	74,577	Not available													SPECTRUM, 2019
Orphans (maternal, paternal, double)	2,303,582		Not available		THIS, 2016-2017										
Notified TB cases (Yr.)	65,505		5,313		5,200		3,619		3,184		18,929		32,764		The National Tuberculosis and Leprosy Program_ The 2016 Annual Report
% of TB cases that are HIV infected	21,627	100	806	4	884	4	837	4	678	3	8,298	38	10,124	47	The National Tuberculosis and Leprosy Program_ The 2016 Annual Report
% of Males Circumcised	Males 15-29yrs	80%			Not available	Not available			Not available	Not available			Not available	Not available	THIS, 2016-2017
Estimated Population Size of MSM*	49,700	Not available													Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
MSM HIV Prevalence	25%	Not available													Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014

Standard Table 2.1.2: 90-90-90 cascade: HIV diagnosis, treatment and viral suppression*

Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate (#) ¹¹	HIV Prevalence (%)	Estimated Total PLHIV (#) ¹²	PLHIV diagnosed (#) ¹³	On ART (#) ¹⁴	ART Coverage (%) ¹⁵	Viral Suppression (%)	Tested for HIV (#) ¹⁶	Diagnosed HIV Positive (#) ¹⁷	Initiated on ART (#) ¹⁸
Total population	55,890,747	4.9 ¹⁹	1,643,666	1,436,570	1,178,506	72%	90% ²⁰	13,372,080	315,804	300,106
Population <15 years	24,354,484	0.4	78,949	65,778	59,637	76%	71% ²¹	1,538,467	13,413	12,783
Men 15-24 years	5,406,712	1.24 ²²	54,022	27,188	21,446	40%	75% ²³	990,174	3,070	7,744
Men 25+ years	9,699,016	5.9% ²⁴	573,626	441,303	354,976	62%	91%	2,934,373	110,000	102,107
Women 15-24 years	5,475,698	2.28 ²⁵	102,426	88,441	70,308	69%	83%	2,692,540	38,899	36,096
Women 25+ years	10,954,837	7.6%	834,641	813,862	719,815	86%	94%	5,087,351	140,763	139,833
MSM	49,700 ²⁶	25 ²⁷	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
FSW	155,450	26	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
PWID	30,000	36	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available

¹¹ National Population Projection, Feb 2018

¹² SPECTRUM Estimates 2019

¹³ NACP & PEPFAR Program Data FY19

¹⁴ NACP & PEPFAR Program Data FY19

¹⁵ NACP & PEPFAR Program Data FY19

¹⁶ NACP & PEPFAR Program Data FY19

¹⁷ NACP & PEPFAR Program Data FY19

¹⁸ NACP & PEPFAR Program Data FY19

¹⁹ Tanzania HIV/AIDS Indicator Survey (THIS) 2016-2017 (15+ yrs)

²⁰ Tanzania HIV/AIDS Indicator Survey (THIS) 2016-2017

²¹ Tanzania HIV/AIDS Indicator Survey (THIS) 2016-2017

²² SPECTRUM estimates 2019

²³ PEPFAR Program Data FY19

²⁴ SPECTRUM estimates, 2019

²⁵ SPECTRUM estimates 2019

²⁶ Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014.

²⁷ Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014.

Priority Pop (Adolescent Girls and Young Women)	6,211,713	3.8 ²⁰	Not available	236,045 ²⁰	Not available					
Priority Pop ³⁰ Estimated Size of Priority Populations Prevalence (Military Community)	61,632	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available

²⁰ SPECTRUM Estimates, 2019

²⁰ SPECTRUM Estimates, 2019/ National Population Projection, Feb 2018

³⁰ Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014.

Figure 2.1.3: Updated National and PEPFAR/Tanzania Currently on Treatment

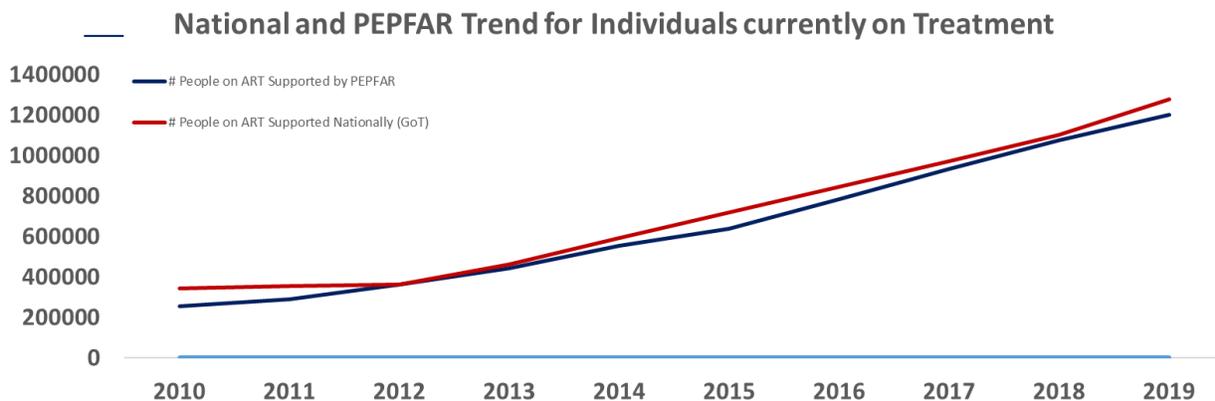


Figure 2.1.4: Updated Trend for New HIV Infections and All-Cause Mortality Among PLHIV

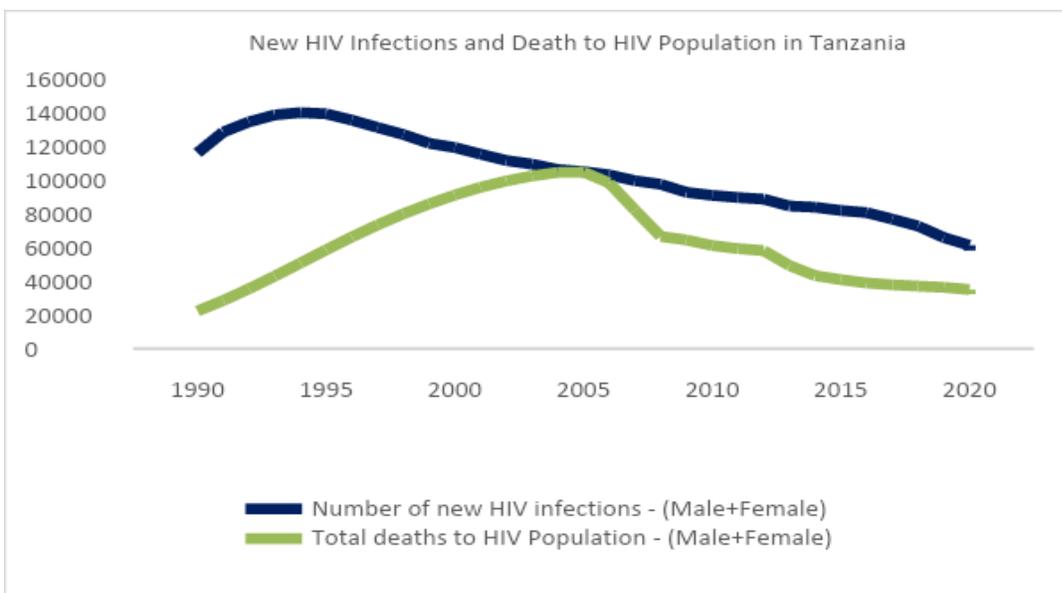


Figure 2.1.5: Progress retaining individuals in lifelong ART in FY19

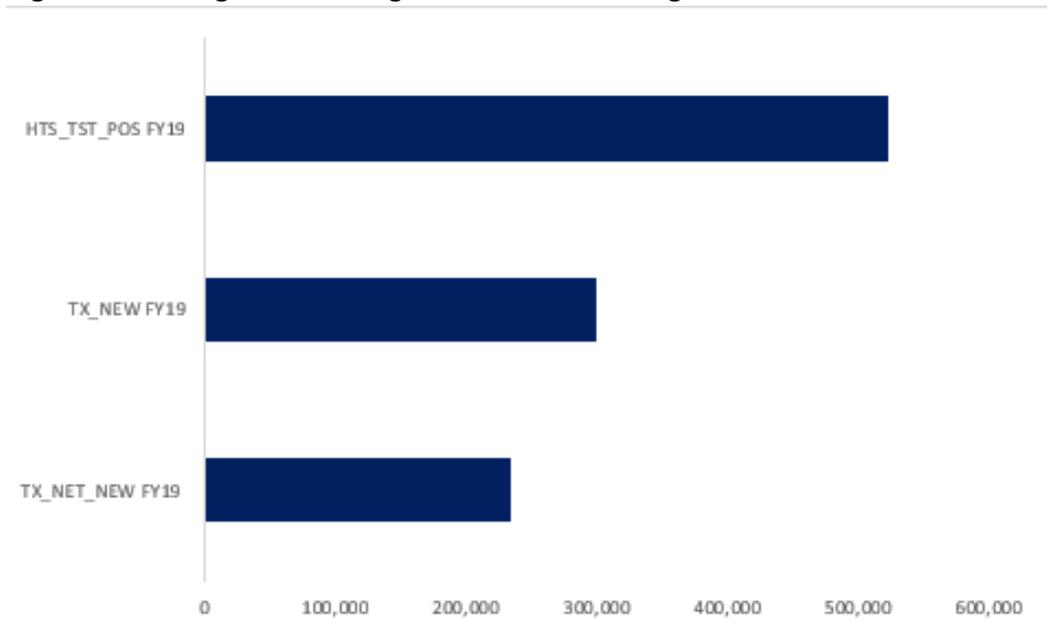


Figure 2.1.6: Proportion of clients lost from ART 2019Q4 to 2020 Q1

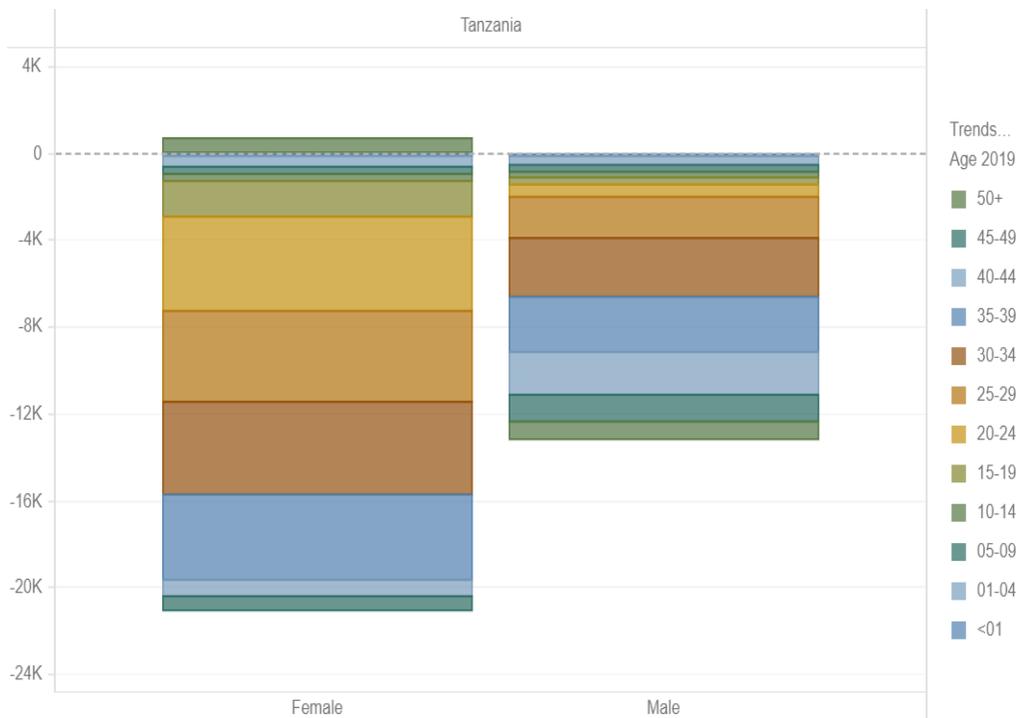


Figure 2.1.7: Tanzania Epidemiologic Trends and Program Response

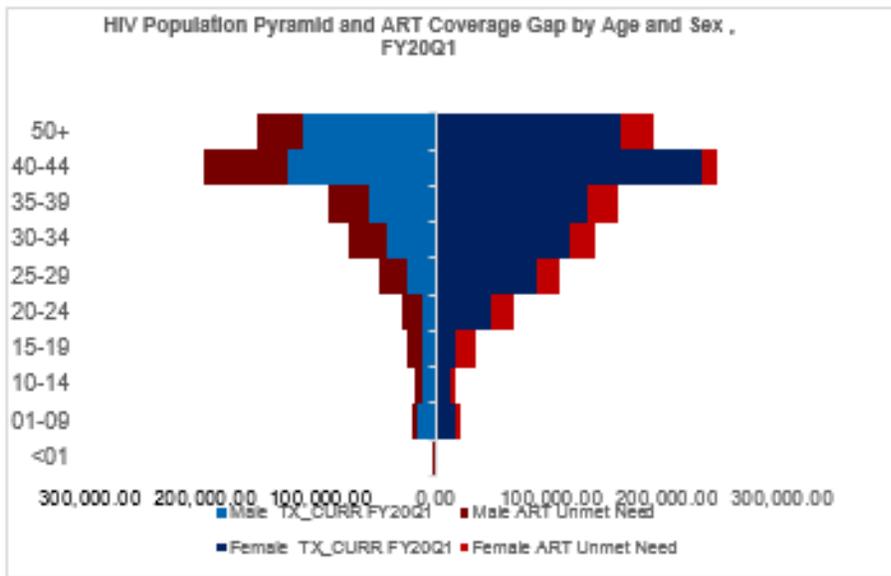
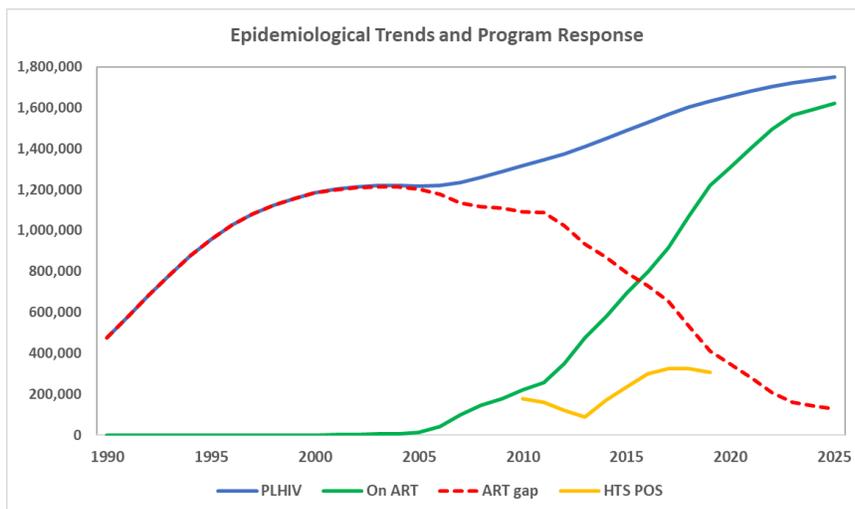


Figure 2.1.8: Epidemiological Trends and Program Response



Source: PEPFAR Tanzania Programmatic Data (FY19 APR, FY20Q1) and UNAIDS Spectrum 2019 Estimates

2.2 New Activities and Areas of Focus for COP20, Including Focus on Client Retention

Beginning in COP19 Q1 and Q2, PEPFAR/T successfully introduced a variety of novel interventions to improve case finding, linkage, and retention. Key initiatives included acceleration of index testing at facility and community settings; optimized provider initiated counseling and testing (with a standardized risk assessment to determine eligibility); same-day ART initiation and linkage case management at facility and community settings; appointment reminders preceding clinic dates; same day tracking of missed appointments with community-facility collaboration for enhanced tracing of lost clients; and enhanced site-level use of data for continuous quality improvement focused on priority indicators.

The successes and experiences of implementation are being scaled up to smaller PEPFAR/T supported sites, while supporting sustained optimal performance at larger sites. Continued improvements in health information systems and utility of the national electronic reporting system, including adoption of a national unique identification strategy, will further facilitate scale-up of these client-centered strategies at all levels.

During COP20, PEPFAR/T, in collaboration with the GoT, will seek to leverage the U=U message to support and enhance retention efforts, medication adherence, and early initiation on ART. In addition, the U=U campaign will further be leveraged to combat HIV-related stigma. Anticipated community engagement activities carried out through implementing partners will include health education and promotion, dissemination of U=U materials, as well as policy and advocacy activities at the national, regional and district levels. U=U messaging will be disseminated and shared in clinical settings, via community outreach events, on websites, and social media platforms. Primary messages will include medication adherence, prevention of sexual transmission of HIV, viral load monitoring, staying undetectable, and other relevant prevention considerations. Additionally, PEPFAR/T will train and capacitate health care workers about U=U and how to communicate the message and support their clients living with HIV.

To close the gap in pediatrics, including improvements in early infant diagnosis (EID), we will implement a program-wide “sweep” to ensure all women living with HIV (WLHIV) have recorded HIV index testing of their children under the age of 15 years. Children of pregnant WLHIV will be a priority of the elimination of mother-to-child transmission (EMTCT) program. Two-month Early Infant Diagnosis coverage will be closely monitored at the site level for HIV-exposed infants. PEPFAR/T will also improve coordination between facility partners and the orphans and vulnerable children (OVC) program to strengthen pediatric HIV case management.

PEPFAR/T will also implement a modified “Operation Triple Zero” strategy to address retention and low viral suppression among adolescents and young persons. While HIV testing at the first ANC remains high in Tanzania, PEPFAR/T, in collaboration with GoT, will implement a risk screening approach to determine which pregnant women should be targeted for a serial HIV testing. This approach will not only help identify additional WLHIV but will be critical to eliminating mother to child transmission in Tanzania.

To improve retention in key and vulnerable populations, including men, PEPFAR/T will continue to implement the Bukoba Combination Prevention Evaluation (BCPE) linkage case management model for new clients. The National HIV service delivery model was updated in COP19 to include linkage case management (LCM) for 60 days following HIV diagnosis to support early retention and rapid progress towards viral suppression. Programmatic data indicate that risk of loss is greatest in the first six months of care. In addition, young adults (20-

29 years old) are at substantially increased risk for loss. Based on these data, during COP20 PEPFAR/T will explore extending LCM beyond 60 days for at-risk individuals.

All PEPFAR/T supported community implementing partners will scale-up Community ART refills by offering multi-month dispensing through mobile clinics. The reach of these mobile clinics will be further extended through use of motorbikes that can bring services to remote villages and settlements. Additionally, mobile pharmacies and motorbikes will be operated by trained healthcare workers (HCWs) recruited by the Regional/Council Health Management Teams. PEPFAR/T will scale-up the reach of the use of the text (SMS) reminder messages to reinforce appointment attendance. Furthermore, through the collaboration of facility and community implementing partners (IPs), specific focus will be to improve tracking of clients through community peers/volunteers.

The combination of targeted facility and community-based HIV testing, expansion of LCM past 60 days for high-risk groups, and the use of mobile differentiated service delivery models for community ART refills, together strengthen a client-centered model. This approach will aim to both facilitate improved diagnosis and viral suppression among underserved populations in Tanzania, including young men and KVPs, and alleviate the burden of expanded ART client loads on health facilities.

Gaps in the clinic-laboratory interface can also interfere in the delivery of timely and quality laboratory services, including Early Infant Diagnosis and viral load testing. Specific challenges include inappropriate specimen collection, storage, packaging and transportation; incomplete documentation in test requisition forms; misidentification of eligible patients; missing and undocumented test results; and inadequate utilization of test results in routine patient management. To address the challenges, PEPFAR/T and GoT plan to improve training at the facility level, introduce monthly indicators tracking key components of the testing cascade and other indicators as deemed necessary, and strengthen the health information systems tracking specimens and test results. PEPFAR/T will also participate in a newly revived National Lab TWG, coupled with monthly supply chain meetings this forum will ensure minimal interruptions in the lab commodity supply chain.

2.3 Investment Profile

The GoT aligns with the Fast Track Targets and the Sustainable Development Goals (SDGs) and its commitment to end the HIV/AIDS epidemic by 2030 remains strong. Both the Tanzania commission for AIDS (TACAIDS) and the National AIDS Control Program (NACP) have developed ambitious strategic plans with targets expanding ART coverage to 95% for all PLHIV by 2025 and reducing new infections to only 15,000 annually by 2023¹¹. However, domestic financing remains a fraction of the total HIV spending. The Tanzania HIV and AIDS response is almost entirely donor funded. The major donors include the U.S. Government, Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund/GF), The United Nations Children's Fund (UNICEF), and The United Nations Development Programme (UNDP). Although external contributions for the HIV response has increased since the publication of Tanzania's HIV Investment case 1.0 in 2016, domestic contributions have not increased significantly. Total HIV financing grew from USD 354.5 M in 2015 to USD 606.8 M in 2017. PEPFAR and the Global Fund accounted for 88% of financing in 2015 and 2016 and 90% in 2017. Several other donors

¹¹ TACAIDS (2018). Tanzania National Multisectoral Strategic Framework for HIV and AIDS 2018/19 to 2022/23

and partners beyond PEPFAR and the Global Fund have provided small amounts of financial support and technical assistance.¹²

In 2017, the estimated domestic contribution was USD 52.3 M, less than 10% of total HIV expenditure. Domestic resources have increased over time, from USD 36.8 M in fiscal year 2014-2015 to USD 52.3 M in 2016-2017, a 42% rise over the three-year period. Looking further back, from July 2011 to June 2014, the 3-year total funding was USD 78.7 M, and this increased to USD 138.8 M from July 2014 to June 2017. These contributions from the GoT are primarily in the areas of human resources, logistics support, and infrastructure, with relatively little spending on commodities.

Table 2.3.1 Annual Investment Profile by Program Area¹³

Program Area	Total Expenditure	% PEPFAR (Oct 2020-Sept 2021)	% GF (Jan-Dec 2020)	% Host Country June 2020-July 2021)*	% Other (Jan-Dec 2020)
Clinical care, treatment and support	357,078,619	73%	27%	0	0.2%
Community-based care, treatment, and support	600,000	100%	0	0	0
PMTCT	5,645,554	76%	24%	0	0
HTS	47,080,913	84%	16%	0	0
VMMC	22,851,730	100%	0	0	0
Priority population prevention	31,790,920	79%		0	5%
AGYW Prevention			16%	0	
Key population prevention	5,963,539	44%	56%	0	0
OVC	130,322,848	88%	0	0	12%
Laboratory	11,927,925	100%	0	0	0.2%
SI, Surveys and Surveillance	32,285,231	22%	77%	0	1%
HSS	11,455,877	67%	26%	0	7%
Other	96,460,018	90%	10%	0	0
Total	653,461,174				

*Note that the budget for this time period has not yet been set.

Although HIV financing trends in Tanzania were upward during 2015-17, the COP19 funding cycle was a 23% decline from COP18 to unsatisfactory country program performance.¹⁴

Tanzania has benefitted from increasing HIV expenditure over the past decade, but the low levels of current domestic financing present several challenges. The HIV response has a high dependence on external funding, but this external financing is likely to either stabilize or decline over the next few years. It becomes increasingly pertinent for Tanzania to identify new approaches to optimize the impact of the available funds given the likely stagnation at current levels for the HIV response in Tanzania. Domestic resource mobilization and optimization will both be critical determinants of the future of the response. Currently, the domestic funding is mainly for human resources, infrastructure, and program management, rather than for commodities and treatment, which is the largest program expenditure. Critical prevention services are also mainly financed by donors. Nevertheless, Tanzania is currently in the process of developing the proposal for the Global Fund funding request for the 2020 – 2022 allocation

¹² (2019). Tanzania HIV Investment case 2.0

¹³ (GRP, National AIDS Spending Assessment , 2012), all amounts in 2012 USD

¹⁴ (2019). Tanzania HIV Investment case 2.0

period, a total of USD 379,740,423 is allocated to Tanzania over the course of those three years (2021-2023). UNICEF and WHO are also expected to provide USD 776,564 for above site interventions such as health information system over the course of year 2020.

PEPFAR/T will continue to collaborate and coordinate with GoT and the Global Fund to address key human resources for health gaps that stand as key barriers to fully implementing activities required for epidemic control involving civil society on strategy and key activities. The investment will target allocative efficiency and improved performance of community health workers using evidence-based approaches to estimate the site level needs and client-centered approaches.

In COP20 PEPFAR/T will finance 73% of clinical care, treatment and support, 100% of Voluntary Medical Male Circumcision (VMMC), 88% of orphans and vulnerable children (OVC), 100% of laboratory activities, 76% of prevention of mother to child transmission of HIV (PMTCT), 79% for priority population prevention, and 67% for health systems strengthening. If the Global Fund maintains the same level of funding as in previous years, the Global Fund is expected to dedicate about 84% of its grant budget in FY20 to commodities.

The budget split for commodities between PEPFAR/T and the Global Fund indicates one of the strongest areas of collaboration between the two largest donors for the HIV response in Tanzania. The Global Fund will prioritize ARVs and Laboratory commodities including RTKs while PEPFAR/T will also cover ARVs and commodities for PrEP, CTX, TPT, VL, VMMC, and recency tests.

Table 2.3.2 Annual Procurement Profile for Key Commodities

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	\$160,000,000	40	60	-	-
Rapid test kits	15,000,000	-	100	-	-
Other drugs	4,000,000	3	-	97	-
Lab reagents	\$77,000,000	50	-	50	-
Condoms	\$10,000,000	7	51	20	22
VMMC kits	5,200,000	100	-	-	-
Other commodities	\$8,800,000	1	70	29	-
Total	\$280,000,000	-	-	-	-

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	\$13,000,000	\$14,731,066	6	\$31,630,257	These activities are Boresha Afya – Southern, GHSC – PWC, PEPFAR Fellows, Digital Square, TBD-PS3+ and TBD-LILED
USAID TB	\$5,000,000	\$17,531,004	11	\$42,556,644	These activities are Tulonge Afya – FHI360, Boresha Afya Northern, Boresha Afya Southern, GHSC-PWC, CIRCLE-Social Solutions, Mtoto Imara-Baylor , TBD-Police & Prisons, IDDS, Local Organization Network, TBD PS3+, and TBD-TB implementation of Framework Agreement (TIFA)
USAID Malaria	\$44,000,000	\$28,218,115	6	\$120,821,797	These activities are Boresha Afya Southern, GHSC-PWC, Digital Square, GHSC TA- PWC, Tulonge Afya – FHI360, and TBD-PS3+

Family Planning	\$23,000,000	\$25,881,066	10	\$50,460,567	These activities are Boresha Afya Northern, Boresha Afya Southern, GHSC TA– PWC, Shops plus – Abt. Tulonge Afya – FHI360, Meeting Target and Maintaining Epidemic Control (TMEC) EpiC , USAID Social Enterprise Support Activity (UESA), Digital Square, TBD-PS3+, and TBD-LILED
CDC (Global Health Security)	\$2,000,000	\$150,000	2		Co-funding is for FELTP
USAID (Global Health Security)	\$4,000,000*	0	0	0	No co-funding *Projected funds
Peace Corps	2,836,300*	0	0	0	*Appropriated funds - \$ 2,776,300 SPA funds - \$ 60,000
Total	\$66,065,479	\$86,311,251	12	\$245,469,265	

2.4 National Sustainability Profile Update

2.4.1 Tanzania Sustainability Index and Dashboard (SID) 2019 Overview

PEPFAR Tanzania completed the HIV/AIDS SID in 2019 as a routine assessment that happens every two years to characterize the country's sustainability landscape and to assist all HIV/AIDS stakeholders in making informed HIV/AIDS investment decisions. The SID 2019 findings will be used to assess above-site level budgeting priorities in COP20. As the SID is updated over time, it will allow stakeholders to track progress and gaps across these key components of sustainability.

Based on a scoring system that generates responses to specific questions under each domain and element, with a possible maximum of 10 points, the SID assesses the current state of

sustainability of national HIV/AIDS responses across 17 critical elements. The strongest scores are coded dark green (8.5- 10 points) which represents sustainability strength, while the next category is light green (7.0- 8.49) which signifies elements that are approaching sustainability, yellow scores (3.50-6.49) are representatives of areas of emerging sustainability, and red scores signify the weakest score (less than 3.5 points). The lower scores demonstrate areas of vulnerability that require continued significant investments, while the higher scores (light and dark green) demonstrate areas of improving sustainability - thus requiring limited investment. Tanzania's overall performance in the area of sustainability demonstrates that there has been improvement across all four domains as compared to SID 3.0 conducted in 2017 (Fig 2.4.1). However, most of the elements require host country ownership and investments to ensure the gains achieved can be sustained.

Tanzania has received substantial external financing for its national response to HIV and AIDS since the establishment of PEPFAR and the Global Fund. Cross-cutting investments from HIV funding sources have strengthened the health system. However, insufficient investments in HIV and the health sector, in general, have prevented Tanzania from reaching its full potential for sustaining the HIV national response.

Figure 2.4.1: Tanzania Sustainability Index and Dashboard (SID) 2019

Sustainability Analysis for Epidemic Control:		Tanzania				
Epidemic Type: Generalized						
Income Level: Low income						
PEPFAR Categorization: Long-term Strategy						
PEPFAR COP 19 Planning Level: \$409,584,991						
		2015 (SID 2.0)	2017 (SID 3.0)	2019	2021	
Governance, Leadership, and Accountability						
SUSTAINABILITY DOMAINS AND ELEMENTS	1. Planning and Coordination		4.43	5.33	9.50	
	2. Policies and Governance		3.85	6.96	7.83	
	3. Civil Society Engagement		4.17	3.83	7.08	
	4. Private Sector Engagement		4.86	4.13	9.03	
	5. Public Access to Information		5.00	6.00	7.33	
	National Health System and Service Delivery					
	6. Service Delivery		3.38	3.98	6.11	
	7. Human Resources for Health		5.00	5.60	6.96	
	8. Commodity Security and Supply Chain		4.94	4.25	5.10	
	9. Quality Management		5.19	5.62	5.76	
	10. Laboratory		3.33	5.83	6.56	
	Strategic Financing and Market Openness					
	11. Domestic Resource Mobilization		1.94	3.21	5.32	
	12. Technical and Allocative Efficiencies		3.17	4.67	4.93	
	13. Market Openness	N/A	N/A		9.33	
	Strategic Information					
	14. Epidemiological and Health Data		4.70	4.17	6.35	
15. Financial/Expenditure Data		4.58	5.00	8.33		
16. Performance Data		5.99	6.97	7.00		
17. Data for Decision-Making Ecosystem	N/A	N/A		6.33		

2.4.2 Sustainability Strengths

Out of the four critical SID 2019 domains and the respective elements, the *Governance, Leadership and Accountability* domain has scored dark green in two elements and light green in three elements. The *Policies and Governance* element within the *Governance, Leadership, and Accountability* domain demonstrated the greatest improvement by being scored at 9.50 points compared to 5.33 points in 2017. The documented improvements are largely due to recent

developments across various platforms that have improved engagement and participation of Civil Society Organizations including strengthened involvement of civil society organizations (CSOs) and faith-based organizations (FBOs) in service provision, representation in policy decisions and accountability. Also contributing to the high scores were the adoption of key policies and guidelines through provision of updated circulars and revised National Guidelines for the Management of HIV and AIDS (2019) that happened after the COP19 planning meeting in Johannesburg, including review of same-day ART initiation from 14 days to within seven days, six month multi-month dispensing (MMD), and the release of new HIV Testing Guidelines 2019. The GoT has also demonstrated strong political will by adopting the much-awaited amendments of the HIV and AIDS Prevention and Control Act (HAPCA) to allow for HIV self-testing in adults and lowering the age of consent from 18 to 15 years (approved in November 2019). Some critical areas that will require increased efforts and attention are the policies and guidelines to ensure legal protection for all key population groups. PEPFAR Tanzania has been working closely with the Tanzanian government to address challenges around this area using diplomacy and focused program implementation efforts.

The National Health System and Service Delivery, is another area of emerging sustainability that made substantial improvements in all the elements compared to SID 2017. This domain demonstrates an overall increased capacity of in-country service providers to deliver HIV services from the national level to the sub-national levels, with local experts leading in provision of technical support. The national supply chain system is showing some improvements. The holistic supply chain review conducted in 2017 showed the roadmap and responsibilities of each key player including the host Government, PEPFAR and the Global Fund. The country has also invested in task sharing to fill the critical gaps in HIV service delivery.

On the *Strategic Financing and Market Openness*, there are some improvements from SID 2017 due to the government developing a strategy to mobilize domestic financing through the AIDS Trust Fund (ATF) under the TACAIDS. SID 2019 had a new element; *Market Openness*, which has generally shown that there are no prohibitive government or donor policies for different stakeholders in provision of HIV services in Tanzania.

Other areas that demonstrated marked improvements included the *Performance Data and Financial and Expenditure Data* elements under the *Strategic Information* domain, which is aligned with increased GoT leadership through MOH and TACAIDS to collect HIV expenditure data and improved efforts to strengthen and harmonize information systems for data use and decision making. PEPFAR has continued to support the roll out of Direct Health Facility Financing (DHFF), Facility Financial Accounting and Reporting Systems (FFARS) that will strengthen the public financial management (PFM) to primary level health facilities (health center and dispensaries).

In addition, Activity Based Costing and management (ABC/M) that is being implemented in FY20 as a core component of PEPFAR's financial sustainability brings together elements of both financial and functional responsibility aiming at improving the efficiency, cost-effectiveness, and quality of HIV – related service delivery and broader health services.

2.4.2 Sustainability Vulnerabilities

The SID exercise also helped identify critical issues that require further investments and ownership to ensure sustainability. Within *Governance, Leadership and Accountability* domain, despite some improvements in engagement with CSOs, FBOs and private not-for-profit organizations, the private for-profit and private health services providers' engagement still needs

further support and incentives to participate in the planning, coordination and implementation at all levels. Even though several coordination structures and mechanisms are in place, further investments are needed to strengthen their capacity, consistency in implementation, and accountability to HIV epidemic control initiatives.

Engagement with the private sector is an important element in sustainability of the gains. The policies and systems to engage with the private sector do exist in Tanzania, however the actual implementation is inconsistent across different intervention areas and geographic locations. TACAIDS creates an enabling environment by serving as champion for multi-sectoral involvement in HIV/AIDS programming in the country. When considering the private sector within *the Governance, Leadership and Accountability* domain, the review team considered both the private, for-profit sector, as well as the private, not-for-profit sector. FBOs primarily fit into the latter category. Tanzania has made progress engaging with the private sector; however, this has disproportionately been dominated by non-profit entities, and the government provides more channels and opportunities for this engagement. For example, faith-based facilities can achieve certain criteria or standards that enable them to receive HRH and operational cost support through existing service level agreements. Such service agreements are not available in private for-profit entities which may only be eligible to receive some health commodities and reporting support. Deliberate efforts to engage with private for-profit entities are needed, especially because there is interest from within the private sector, but capacity is limited for most facilities. In COP20, PEPFAR/T will continue to support and enable the engagement of the private for-profit sector, including local commodity manufacturing companies.

Within the *National Health System and Service Delivery* domain, there is inadequate domestic financing for the procurement of ARVs, HIV rapid test kits (RTKs), condoms, and supply chain related costs. The *Commodity Security and Supply Chain* showed some improvements from SID 2017, however, the Holistic Supply Chain Review revealed weaknesses that require leadership, ownership, and continued investments by the government of Tanzania to reduce donor dependence. Despite ongoing efforts to cover the critical shortage of skilled health workforce, there is an overall low production, absorption, and deployment of health workforce to areas with critical needs. This area needs serious consideration and investment by all key stakeholders. In COP20, PEPFAR/T will continue to engage all stakeholders, especially GoT, to fast track the formalization of community health workers, to ensure availability of appropriate cadres across the HIV continuum of care, particularly at the community level.

2.4.3 Funding for HIV epidemic

In COP20, PEPFAR/T received an increase of 17.6% in funding from \$409,584,992 in COP19 to \$481,800,000. Tanzania continues to implement Global Fund grants and will submit a funding request for the next implementation period 2021 – 2023. In the Global Fund new allocation, Tanzania is getting an increase by 8% in its HIV Grant allocation. Unfortunately, domestic funding from the GoT remains recurrently low. While marginal improvements were made in the domain related to *Strategic Investments, Efficiency and Sustainable Financing*, this was the weakest scoring domain across the sustainability landscape. The national budgets do include funding for HIV/AIDS, but the overall ability to ensure that enough resources are committed to meet the needs in Tanzania remains a continued challenge. Only a small percentage of the national HIV response is financed with domestic resources. Data on government resources allocated to highest burden geographic areas are unavailable. ARV benchmark pricing is not applied by the government because of total dependence on the USG and Global Fund for ARV procurement.

The fiscal environment, together with the elements of *Domestic Resource Mobilization and Technical and Allocative Efficiencies*, is also currently unsustainable, meaning that Tanzania does not adequately generate the necessary financial resources for HIV to ensure sufficient resource commitments, and it does not use data to strategically allocate funding and maximize investments.

In COP20 PEPFAR/T will focus on increasing the transparency and accountability of investments made and advocate with the GoT for increased data sharing on performance, including financial information through resource alignment initiative for effective decision making.

2.3.4 Transition to indigenous partners

PEPFAR/T is committed to continuing and protecting the progress that has been made over the past 16 years in Tanzania. The CSO Engagement Strategy that will be finalized in COP19 (FY20) is providing a systematic engagement and capacity building to indigenous partners. In COP20, USG agencies will continue to promote local capacity, development, and to responsibly transition to ingenious organizations that will effectively fulfill PEPFAR's mandate. To avoid sudden and dramatic shifts that will put our overall impact and results at risk, PEPFAR/T is strategically positioning to contribute to the global goal of having 40% of funds transitioned to local partners in COP19. PEPFAR/T will expand its work with local actors by reengaging local private sector entities to improve and effectively integrate service delivery and system strengthening approaches. PEPFAR/T will expand broad based community service interventions and human resources provision through local partners. The commitment is such that by the end of COP20, PEPFAR/T will be appropriately contributing to the global goal of 70% of PEPFAR funds will go to indigenous organizations. In this transition, PEPFAR/T plans to focus on partner management and engagement to ensure expected program targets are met and the implementing local partners have adequate capacity to maintain the quality of results, manage increased financial resources, and diversify their revenue streams for their stronger sustenance.

2.5 Alignment of PEPFAR investments geographically to disease burden

In order to determine if budgets appropriately aligned with HIV disease burden in Tanzania, COP20 planned spending was mapped alongside the most recent Spectrum 2020 PLHIV estimates. As displayed in Map 1, many PLHIV reside in the Lake Zone, Southern Highlands, and Dar es Salaam. Therefore, a proportionate amount of the COP20 budget will be invested in those geographic areas.

Map 1: Number of PLHIV by Council as compared to COP19 Planned Budget by Council

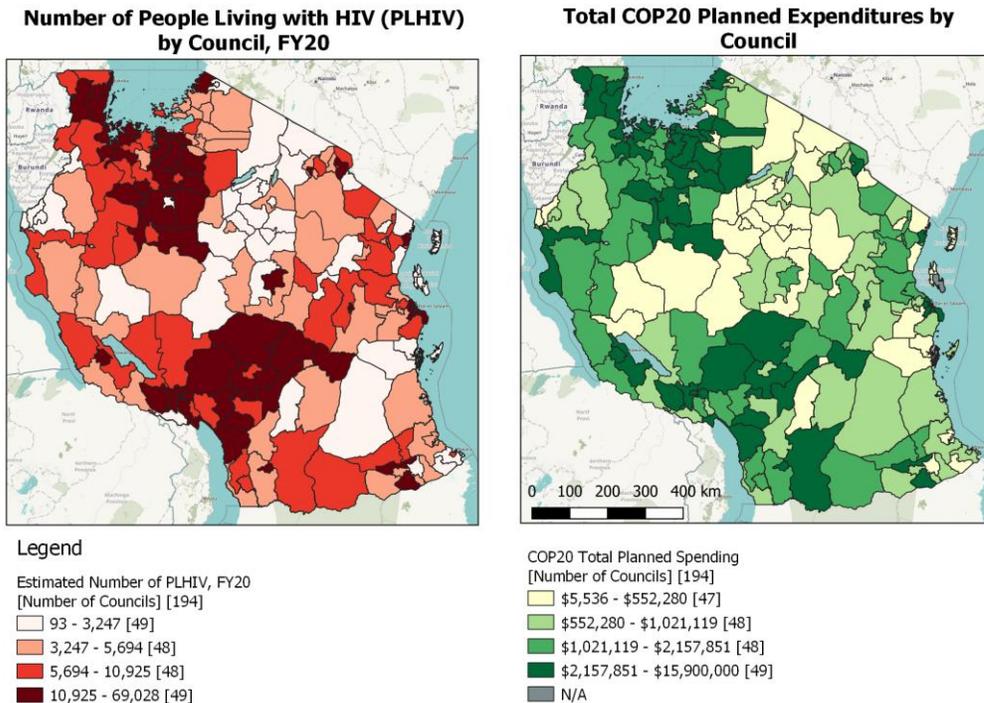
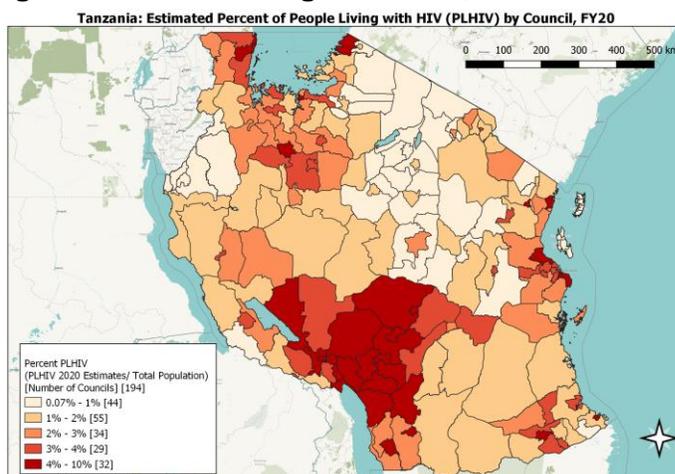


Figure 2.5.1 displays the percentage of PLHIV, estimated number of PLHIV, ART treatment coverage, and most recent viral load monitoring coverage for Tanzania. Councils with high HIV burden (within the highest quartile of PLHIV burden) also have the highest ART coverage, as seen in the Lake Zone and Southern Highlands.

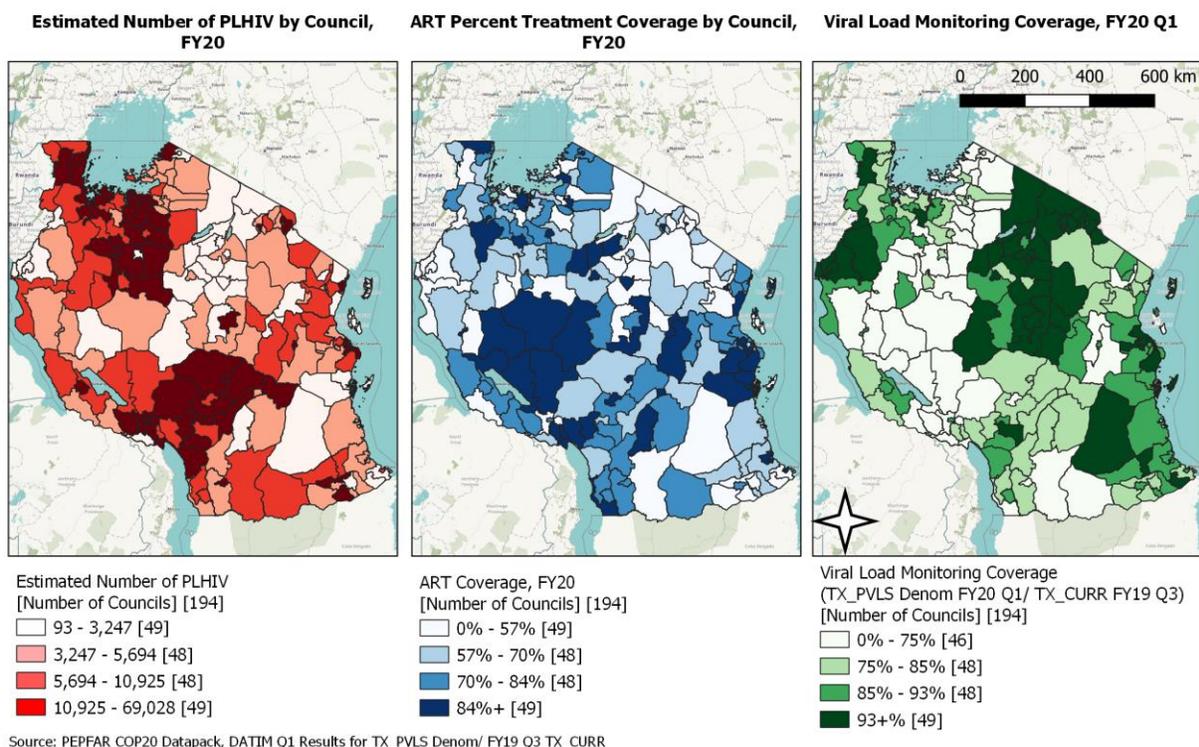
Figure 2.5.1: Percentage of PLHIV, estimated number of PLHIV by Council



Map 2 shows that the scale-up of viral load capacity in the past year has resulted in clear improvements; with newly established viral load labs providing further coverage across the country.

Map 2: PLHIV, ART Coverage and Viral Load Coverage by Council

Tanzania: People Living with HIV (PLHIV), ART Coverage and Viral Load Monitoring Coverage by Council



2.6 Stakeholder Engagement

PEPFAR/T engaged external stakeholders to develop COP20 beginning in December 2019 when the COP20 draft guidance was shared with GoT representatives, CSO representatives, development partners, UN agencies, and implementing partners. These stakeholders were encouraged to provide feedback to the Office of the U.S. Global AIDS Coordinator (OGAC) through the designated channels.

In mid-December 2019, PEPFAR/T leadership shared the COP20 timelines with all stakeholders - GoT (TACAIDS, Presidents Office Regional Authority and Local Government (PO-RALG), and MoHCDGEC), CSOs, and Development Partners. Stakeholders were requested to select representatives to attend the in-person meeting in Johannesburg in order to ensure their full participation in COP20 planning process. During the same period, the PEPFAR/T Coordination Office attended a CSO COP20 preparation meeting and presented COP20 priorities as outlined in the draft COP guidance. In mid-January 2020, the final COP20 Guidance and the Planning Level Letter were shared with all stakeholders.

During the week of January 27, 2020, PEPFAR/T held a COP20 Strategic Planning Workshop during which the COP20 programmatic, technical, policy priorities, various COP inputs, and tools were discussed. Since COP20 planning coincided with the Global Fund 2020-2022 allocation period planning, the Global Fund guidance and timelines were also discussed to identify areas of common policy interest and areas of possible program overlap, with the goal of ensuring complementary activities. More than 190 stakeholders attended the meeting - the GoT representatives (52), bilateral and multilateral development partners, including the Global Fund

(15), implementing partners (36), civil society (30), and PEPFAR interagency team (60). Consensus was formed around minimum policy requirements and funding allocations between PEPFAR and the Global Fund to ensure no duplication of effort. Time was dedicated to sensitizing participants on the COP tools, such as the Funding Allocation to Strategy Tool (FAST) and developing the assumptions for the Data Pack through detailed Spectrum analysis. The HIV commodities allocation was also discussed and agreed in consensus with the Global Fund and GoT in line with the national supply plan.

During the COP20 planning, PEPFAR regularly engaged with Tanzanian CSOs to ensure their involvement in the planning process. Through a democratic process, CSO groups namely, Non-State Actors (NSA), Key and Vulnerable Population (KVP) Forum, NACOPHA, and the Adolescent and Young Adults (AYA) Steering Committee elected representatives to attend the COP20 in-person meeting in Johannesburg. The NSA held a COP20 introduction meeting in mid-January, during which time the PEPFAR Coordinator reviewed the COP20 guidance, highlighting key areas for strategic focus (with an emphasis on community-led monitoring), as well as the notional funding allocations. The CSO representatives subsequently engaged their constituencies to develop a presentation on COP20 CSO Priorities that was presented during the Strategic Planning Workshop in Dodoma. Based on the feedback provided during the Strategic Planning Workshop, the CSO representatives continued to engage with their constituencies to develop a final presentation for Johannesburg. The PEPFAR interagency team collaborated closely with CSOs to develop the foundation for the proposed community-led monitoring approach. Several meetings were convened to identify the indicators, methodology, reporting structure, and geographic areas of focus. CSOs will be fully engaged in implementation of the community-led monitoring (CLM) activities under UNAIDS coordination. Findings from CLM will be discussed with GoT and recommendations for improvements related to client-centered HIV care and treatment reached in consensus.

The faith-based umbrella organizations, including Tanzania Interfaith Partnership (TIP), Council of Pentecostal Churches Tanzania (CPCT), and Pastoral Activities and Services for People with AIDS Dar es Salaam Archdiocese (PASADA), participated in the Strategic Planning Workshop held the week of January 27. PEPFAR/T has continually engaged the faith-based entities in the development of the Faith and Community Initiative (FCI) to support the continuation of key activities for communities in raising awareness, HIV case-finding/linkage/retention, and prevention of sexual violence and HIV risk among ages 9-14 years in COP20.

The GoT selected a delegation of six representatives to attend the Johannesburg meeting, including the Chief Medical Officer at MOH, two representatives from National AIDS Control Program (NACP), a representative from TACAIDS, PO-RALG, with the Honorable Deputy Minister of Health as the head of the delegation. Several pre-meetings were held with PEPFAR/T and GoT representatives to discuss policy and the minimum program requirements for COP20. The group also discussed the implementation status of COP19 as compared to the previously agreed upon COP19 minimum policy requirements. These COP-focused meetings complemented the on-going monthly technical meetings between PEPFAR and GoT, which have continued regularly since the COP19 in-person meetings. The Global Fund Country Team, UNAIDS, WHO HQ, and Tanzania Country Office representatives also attended the COP-focused and monthly meetings and were present in Johannesburg. A large stakeholder meeting was convened in Tanzania the week after the Johannesburg discussions. Senior leadership from GOT, CSOs, IPs, PEPFAR staff, and development partners were all present to hear about the discussions and decisions from Johannesburg that will be part of the final COP20 strategy.

As the COP is finalized and throughout FY20 and FY21, PEPFAR/T will continue to engage CSOs, GoT, UN Agencies, and other stakeholders as key members of Tanzania's Development Partners Group on HIV/AIDS to collaborate on strategies that ensure Tanzania is on track to achieve epidemic control. The purposes of the monthly meetings between PEPFAR/T and the MoHCDGEC technical staff are to share and review monthly PEPFAR/T data, review policy adoption and implementation, and ensure implementation continues during COP19 and COP20. The same monthly meetings are chaired by the Minister of Health on a quarterly basis to provide a platform to discuss and address serious bottlenecks that hinder program implementation, especially policy implementation of accepted best practices. PEPFAR/T will continue regular engagement with the Global Fund in order to coordinate procurement of commodities procurement, supply chain coordination, and to ensure program activities are complementary.

In COP20, involvement of private sector in provision of services is prioritized. A private sector ART service model aimed at promoting self-testing and retaining youth on treatment will be piloted around dense and sexually active youth populations surrounding vocational training centers, colleges, and universities. Youth-friendly ART pick-up sites will include a network of private health facilities, pharmacies, and testing, care and treatment centers. Digital applications and youth-centered messaging that encourage self-referral will be part of the marketing strategy.

3.0 Geographic and Population Prioritization

Table 3.1 below summarizes ART saturation and categorizes geographic areas accordingly. PEPFAR Tanzania has attained ART coverage in 11 Districts within 10 regions with a prevalence range of 3-10%. Almost all the 11 districts represent urban areas with high HIV prevalence. COP20 program planning prioritize these districts through ambitious targets in Dar es Salaam, the regions/districts surrounding Lake Victoria, and transportation corridors in the Southern Highlands.

According to the 2016-2017 THIS, of the 7 million men aged 15-29, 57% had received a VMMC, leaving a remaining gap of 1.7 million men to be reached. Since 2017, PEPFAR/T conducted more than one million circumcisions, reaching a national male circumcision (MC) prevalence near 80% among men 15-29 years old. Despite this overall success, substantial geographic and demographic gaps remain -- Shinyanga and Simiyu (two regions adjacent to Lake Victoria) have MC prevalence of only 46% among men aged 15-29 years. This MC coverage gap is further compounded by the high HIV prevalence among fisherfolk in the Lake Victoria area (three times higher than the national prevalence). Factors affecting adult male uptake of VMMC services include distance to facility, lack of privacy due to structural set-up of facilities, economic constraints, emotional reservations, perceived irrelevance, and traditional and cultural norms. PEPFAR/T applied for, and was awarded, VMMC ambition funds in COP20 to close the MC gap in these regions.

PEPFAR/T is currently operational in 197 councils in the country. COP20 plans will build on the programmatic shifts operationalized in NAOMI model estimates. PEPFAR/T reviewed epidemiologic data and burden of disease at the council level, including population density and total number of PLHIV and unmet need for ART.

Based upon progress made in service delivery during COP18 and COP19 and revised PLHIV estimates, COP20 key interventions will be prioritized in districts with greatest burden and gap

in coverage. Although districts within Dar es Salaam, Lake Victoria area, and Southern Highlands have made significant progress in improved identification, gaps remain in ART coverage. Four of the five districts in Dar es Salaam have the highest PLHIV burden among scale-up districts and are being prioritized for enhanced activities in COP19 and COP20. Among the 35 districts within the Lake Region, seven districts (across four regions) maintain the largest unmet coverage needs and will continue to be prioritized for enhanced programming including KVP activities. Within the southern highlands, significant progress has been made and, based upon COP20 targets, the 24 scale-up districts are on track to reach 90% ART coverage.

In COP20, PEPFAR/T will continue to prioritize case finding among men and AGYW. Tanzania has shown impressive progress and reached 90-90-90 (73% community viral suppression) in COP19 Q1, but the case finding gaps in men and children lags behind. For example, PEPFAR Tanzania will enhance efforts to target men 15-49 years old in Ruvuma, Mtwara, and Morogoro regions, which shows the highest gap in treatment coverage for men. The three regions will be targeted with a standardized, data-driven, male-centered service package that addresses the entire cascade to be implemented across sites in three regions with highest gaps in finding men. PEPFAR/T applied for and was awarded ambition funds in COP20 to address male case finding in the southern regions of Tanzania. Effective strategies will be identified and scaled-up.

Finally, there remains a large degree of uncertainty in regional level estimates, particularly for Dar es Salaam and the Lake Region (Geita, Mwanza, Kagera, Kigoma, and Shinyanga). To improve these estimates and to ensure that PEPFAR/T resources are aligned with the case finding gap, a Population-based HIV Impact Assessment (PHIA) will be performed in COP20, with attention to sufficiently powered estimates in those key regions.

Table 3.1: Current Status of ART saturation

Prioritization Area	Total PLHIV/% of all PLHIV for COP20	# Expected Current on ART (FY20)	# of SNU COP19 (FY20)	# of SNU COP20 (FY21)
Attained	192,842	161,680	11	11
Scale-up Saturation	1,158,220	966,302	96	99
Scale-up Aggressive	N/A	N/A	N/A	N/A
Sustained	292,605	225,035	83	87
Central Support	N/A	N/A	N/A	N/A

4.0 Program Activities for Epidemic Control in Scale-Up Locations and Populations

Programmatic Priorities for Epidemic Control

In Tanzania, data from the 2016-2017 THIS demonstrate that gaps in case finding are large across all age and sex sub-groups and all geographic areas. With a first 90 of 61%, the lowest

among all countries with substantial PEPFAR funding, identification of people with HIV is Tanzania's single largest gap in achieving epidemic control. During the first quarter of 2020, Tanzania added 78,935 people on ART treatment compared to quarter four of 2019 where only 83,318 clients were on treatment. PEPFAR/T achievements were attributed to scaled-up index testing, optimized provider-initiated testing and counseling (PITC), targeted community-based testing approaches, and reduced over-testing at facility and community-based settings. Although the gaps across the cascade are improving, there is still inequity by age and sex. To reach Tanzania's goals of achieving UNAIDS 95-95-95 targets by 2030, a combination of HIV testing services (HTS) approaches will be required. These include index testing and HIV self-testing to increase identification of PLHIV through client-centered approaches at facility and community-based settings. Despite achievements to date and lessons learned, PEPFAR/T needs to continue working with MoH and IPs to optimize HIV testing and linkage to care and retention of clients on treatment. This can be accomplished by implementing client-centered approaches, including the provision of optimized treatment regimens, differentiated service delivery models (multi-month dispensing), including KP-friendly community services, addressing the needs of each individual. The THIS data show that, while identification is poor broadly, the gap is even larger among some sub-populations, especially men (Figure 4.1).

Fig 4.1: ART Treatment Gaps as of December 2020

Age stratum	FY20 Q1 TX_CURR		2020 PLHIV estimate (Naomi Model)		ART coverage	
	Female	Male	Female	Male	Female	Male
<01	284	227	1,278	1,326	22%	17%
01-04	5,131	4,958	5,891	6,148	87%	81%
05-09	11,801	11,123	14,716	15,196	80%	73%
10-14	13,617	12,531	17,014	17,388	80%	72%
15-19	18,076	10,460	35,486	24,443	51%	43%
20-24	48,711	11,446	66,940	29,579	73%	39%
25-29	88,097	24,331	106,512	48,145	83%	51%
30-34	115,555	42,393	137,725	74,974	84%	57%
35-39	130,778	58,318	158,127	93,868	83%	62%
40-44	127,063	66,058	138,625	107,498	92%	61%
45-49	102,790	63,327	105,510	93,395	97%	68%
50+	159,888	114,517	188,151	155,732	85%	74%
Total	821,791	419,689	975,975	667,692	84%	63%

4.1.1 Finding the missing, getting them on treatment, and retaining them ensuring viral suppression

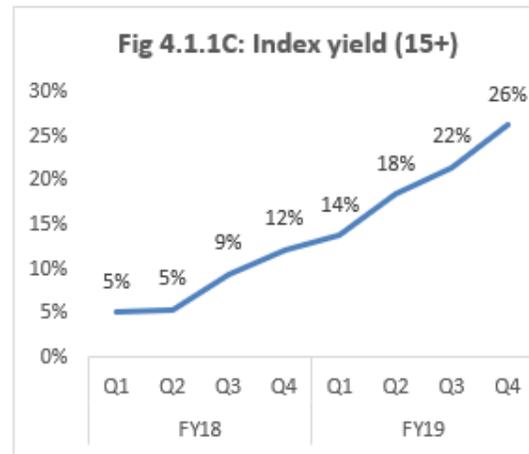
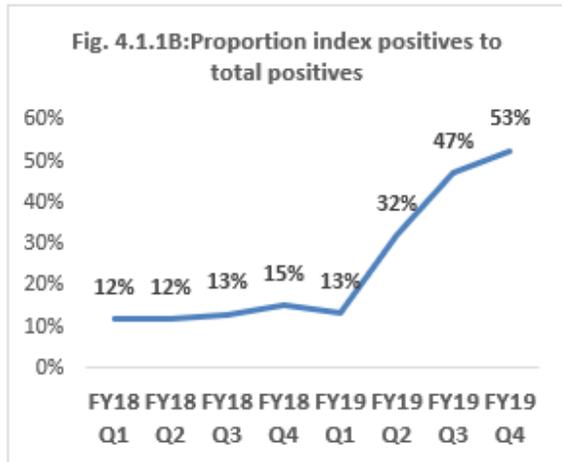
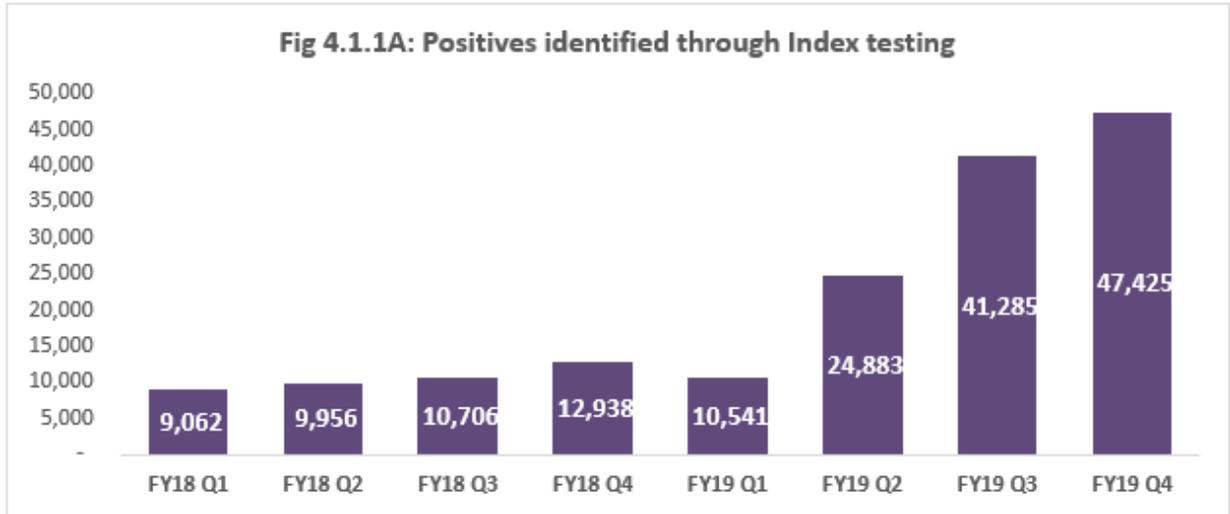
The data from the 2016/2017 THIS suggest a decrease in national prevalence (4.7% overall among 15-49-year-olds; 6.2% for women and 3.1% for men), compared to THMIS 2011-2012 (5.1% overall; 6.2% for women and 3.8% for men). Unfortunately, only 61% of PLHIV were aware of their status, presenting a key challenge to achieving the UNAIDS 95-95-95 goals. Following these findings, PEPFAR/T used a focused approach to align targeted and effective case finding strategies to improve identification. In COP19 planning, PEPFAR/T aimed to increase the quality and focus of the HIV testing, care and treatment services to identify, link and maintain clients in treatment services. To reach 95% treatment coverage in priority regions, PEPFAR/T employed a cascade approach to setting HIV testing targets and considered several

critical program streams and testing modalities to most efficiently identify HIV-positive individuals and effectively link them to care and treatment.

For COP20, PEPFAR/T will continue to address the broad gaps in coverage across age and sex bands through enhanced, evidence-based implementation of three key aspects of HIV case finding client-centered testing approaches: index testing, optimized PITC, and client centered targeted community testing, including peer/social network testing (SNT) approaches for key and priority populations focusing in geographic hot spots on areas where new diagnoses are occurring. Special emphasis will be on the quality of index testing services, including the counseling itself, ensuring these are client-centered, safe, non-coercive, private, and confidential. This will include routine tracing of intimate partner violence and reporting of any related adverse events. PEPFAR/T will continue to strengthen the collaboration with the Government of Tanzania to ensure wider scale up of risk screening for HTS especially at medical outpatient department (OPD) settings. This will include ensuring the proper use of the validated national risk screening tool. This approach focuses PEPFAR/T testing investments where the potential gains are greatest, and where the level of complexity (because of facility size and screening needed) is highest.

PEPFAR/T will establish a standardized and coordinated quality assurance (QA) system for HTS; focusing on both QA for Index testing and Optimized PITC performed by HCWs including support of all services for people diagnosed with HIV at those facilities. As IPs address intimate partner violence (IPV), community and facility partners will strengthen the inclusion of gender - based violence (GBV) screening through PEPFAR/T support by rolling out GBV screening and referrals in HTS settings with a focus in councils shown to have higher risk. IPs will increase capacity of providers to effectively incorporate HIV testing messages, advocate for positive gender norms, and conduct GBV screening into testing and counselling sessions. Trained providers will provide appropriate referrals to safe space/shelters and linkages will be created with support groups and legal services.

PEPFAR/T will continue to increase coverage and fidelity of index testing, social network testing, and optimized PITC through identification of opportunities for maximizing facility based-testing efforts in OPD, PMTCT, TB patients, and suspects. In FY19 PEPFAR/T demonstrated improvements in both the number of index positives identified and testing yield (see figures below).



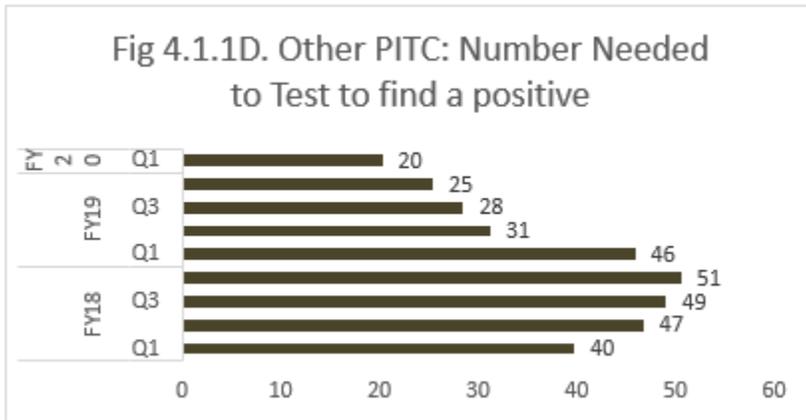
The number of index positives rose from 9,062 in first quarter of FY18 to 47,425 in quarter four of FY19, which is more than five-fold increase within two years (Fig 4.1.1A above). During the same period, the percentage of all positives coming from index rose from 12% (FY18 Q1) to 53% (FY19 Q4) (Fig4.1.1B) while the yield of positives from index testing rose from just over 5% to 26% (Fig 4.1.1C). These results show rapid acceleration of index testing with fidelity. Results from the last quarter of FY19, show that Tanzania achieved its COP19 target of reaching more than 30% of positive clients from index testing with an index yield of more than 20%.

All PEPFAR/T supported facilities implemented index testing, specifically focusing on the scale-up of assisted voluntary partner notification to support index client acceptance, elicitation of contacts, mapping and active tracking of contacts for testing, and linkage to care and treatment services for those who are diagnosed with HIV. At all sites, monitoring of index testing services provision was done throughout the cascade approach, i.e. data on the number of sexual contacts identified per index case, the proportion tested, and the yield was tracked to identify the facilities in which the greatest improvement were needed, and also to identify the specific gaps requiring improvement. This approach demonstrated success in improving results.

<p>COP20 Identification Strategies for Screening Better and Testing Smarter</p> <ul style="list-style-type: none"> • Client centered index testing (facility and facility-led community/outreach) to achieve substantial scale-up in COP19 and COP20, while ensuring safety, non-coercion, privacy, and confidentiality measures are in place in the provision of index testing services • Optimized PITC for increased yields, with focus in high-volume, high-yield facilities using the validated national risk screening tool for each test taking place at OPD • Targeted client centered facility-led community testing used selectively and tailored to needs of men and KVP, PP, and DREAMS • Social Network Testing especially targeting the social networks of KP. This is mainly community-based. • HIV self-testing scale up country-wide

In COP20, the post-contact tracing adverse event screening for index clients will include physical and non-physical violence, undesired disclosure of status, identity, and conditioning of services on participation in index testing, and will be developed with input from civil society organizations. Results of adverse event tracking will be monitored regularly along with performance against other indicators, triggering immediate action and reported in PEPFAR /T monthly reporting portal through partners, POART reviews as part of index testing progress assessment as well as MOH monthly HTS reports. National training curricula and monitoring and evaluation (M&E) materials for index testing (HTS registers including elicitation and adverse event reporting forms) have been developed and rolled out and include HIV self-testing and linkages to treatment.

For optimized PITC, PEPFAR/T will continue to scale up approaches for optimization of HIV testing services at facilities with both high numbers of HIV positive test results and high yield to ensure that PEPFAR/T maximizes the value from this investment. PEPFAR/T will continue ensuring the use of the validated national risk screening tool across supported facilities. The result of this effort will be to continue to optimize yield for PITC in facilities that are PEPFAR/T supported. Compared to the FY18, the number of tests done at OPD settings (Other PITC modality) decreased significantly. From the Figure 4.1.1D below, the number needed to test (NNT) to identify one positive has decreased from 51, which was the highest in FY18 Q4, to 20 in FY20 Q1. This is a substantial reduction of tests.



Furthermore, PEPFAR/T will intensify targeted client-centered, facility-led, community case finding strategies with high yield focusing on KVP in community settings. This will continue to be the key area for the KVP Advisory Committee involvement. In COP20, the program will also focus on testing of the KVP positive social network through social

network testing. The program does not support non-KVP, non-index community, non-targeted campaigns and general population testing approaches. Client-centered, facility-led, community-based testing will focus on high-risk areas informed by mapping of KVP hotspots, concentrations of PLHIV and recent HIV infection surveillance data. PEPFAR/T will also use the risk and symptom-based screening approach to focus testing on high-risk persons. These interventions will increase yield and will decrease testing in low burden areas. Data from PEPFAR/T community activities in COP18 demonstrated quarter-on-quarter improvements in finding men with HIV, whereas facility efforts have had less success in increasing case-finding in men. So, while this approach will have broad benefits in closing HIV case finding gaps, it is especially important in finding men.

In addition, to effectively target client-centered, facility-led, community-based HTS activities, PEPFAR/T will continue to integrate nighttime and moonlight testing activities to better reach key and priority populations and communities surrounding KVP hotspots. These activities have been critical to Tanzania’s success in meeting KVP targets. Implementing partners will focus on venue-based testing, social network testing, and mobile clinic trucks providing comprehensive HIV services (including clinical and lab services) that will help ensure services can be accessed in hard-to-reach communities. Finally, HTS providers will be offered training refreshers on the new revised HTS M&E tools and index testing training package, including competency assessments of non-laboratory HIV rapid testers in community settings as part of the national certification program to ensure the quality of testing. In order to achieve these changes in approach, the IPs will increase the numbers of KVP and PLHIV peer volunteers to cover all districts and fast track HTS at all levels.

PEPFAR/T, in collaboration with GoT, will continue to support the client-centered, facility-led, community ART initiation and refills for KVP (30-day prescriptions), in line with the new MoHCDGEC guidelines. While community refills have been implemented in some regions, nationwide implementation will be implemented in Q2 2020 PEPFAR/T will also strengthen and support PLHIV support groups and networks to improve overall quality of services to increase retention and achieve viral suppression for both adults and children living with HIV.

PEPFAR/T implements activities to ensure strong partnership between community and facility IPs in regions where partner streamlining has not yet been initiated, along with regional and district health teams at the local government authority (LGA) level. Within the regions, IPs meet regularly together and with LGA staff to ensure proper coordination. At the national level, partner management meetings include the facility and community partners together to ensure proper coordination.

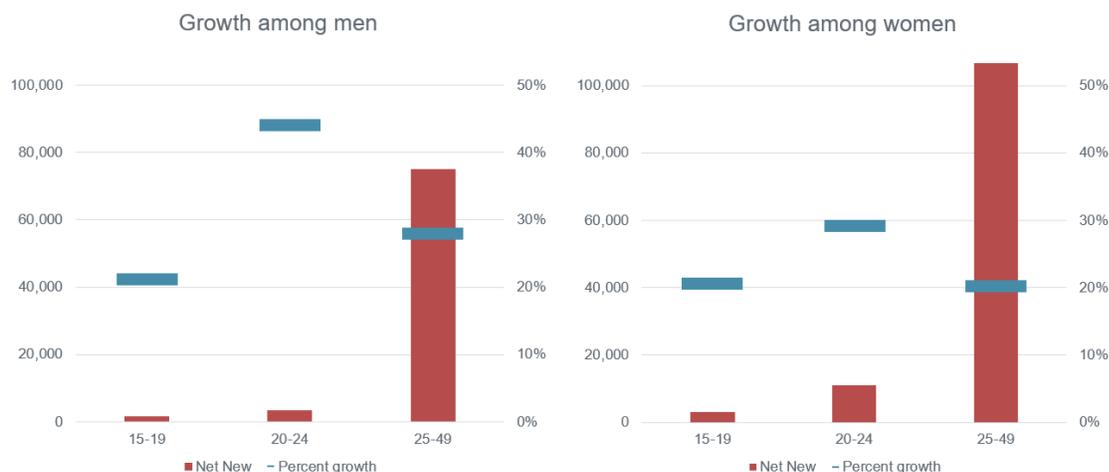
PEPFAR/T will implement the evidence-based linkage case management (LCM) model, assigning all newly initiated PLHIV to a PLHIV expert client for the first 60 days to support adherence to ART and promote early retention. LCM has been prioritized in high-volume facilities, hosting approximately 80% of PLHIV on treatment, and will be scaled out to smaller facilities. Additionally, the emphasis will be on effective bi-directional referral systems, particularly for HIV-positive individuals, for increased access to care and treatment services, as well as for HIV-negative individuals to prevention programs that reinforce risk reduction. M&E efforts will be strengthened to effectively measure not only how many people have been referred from community to facility settings services, but also of those referred, how many have reached and utilized services. Sites and implementing partners will monitor data weekly and monthly and adapt the HTS program accordingly. PEPFAR/T will conduct analysis by population, sub-groups, age, and gender to understand program challenges in identification and use the data to improve client-centered targeted testing and linkage to treatment services.

Adult men

Based on FY20 Q1 program data, PEPFAR/T continues to struggle with identification of HIV-positive men and initiating these men on treatment. Currently, 40% of 2020 PLHIV estimate in Tanzania are men aged 15+ years where ART coverage has remained very low.

Finding men was a priority in 2019. Identification of men improved in terms of the number of new positives identified in 2019 (FY 19 Q1; 26,028 – FY 19 Q4 35,085), along with a substantial increase in testing yield from around 2% to 10%. Over 64% of the positives were identified through index testing services by FY19 Q4, which is evidence of the effectiveness of the strategies for identifying men through index testing. This increase in HIV positives identified, combined with improvements in linkage and community ART described earlier, resulted in quarter-on-quarter increases in TX_NEW for men throughout 2018 and 2019. The growth in TX_NEW resulted in the person-level benefit of increasing the number of men on ART. Figure 4.1.2 illustrates the NET_NEW for each male age group shown, and the percent increase in TX_CURR for the year. It shows close to 45% growth of young men on treatment during the last four quarters.

Figure 4.1.2: Tanzania TX_CURR growth by age and sex (FY19 Q1 to FY20 Q1)



PEPFAR/T will build on these index testing and community testing successes, rapidly improving index testing through partner notification services as an approach to increase identification of males. The community successes came mainly from KVP outreach activities. These activities included outreach to miners, fisher-folk, clients of sex workers, and others. These activities will continue as part of our community outreach KVP activities.

Social Network Testing will be a new client-centered intervention targeting men. Complementing the index testing and HIV self-testing (HIVST) services, PEPFAR/T will scale up this modality especially among the KP, men and adolescents.

Finally, targeted testing through private sector workplace programs has demonstrated success to improve HTS access among men. In collaboration with the Association of Private Health Facilities in Tanzania (APHFTA). PEPFAR/T will intensify this approach by distribution of HIVST in male-dominated workplaces, both public and private.

PEPFAR/T's FY19 annual report showed that viral suppression is consistently lower among males than females across the age groups. To improve treatment outcomes among males, PEPFAR/T will build on COP19 efforts to make clinics more "male-friendly" through extended operating hours, moonlight services, deploying male service providers, enhanced adherence counseling, especially for men with poor viral load results, and use of peer support for close follow-up including appointment reminders to help ensure clients don't miss their appointments. Roll out of the SDM models that includes, multi-month prescriptions – including the new MoHCDGEC approach to providing six-month dispensing - and ART outreach services through facility community ART refills will continue and should help to improve retention by decreasing the need for monthly facility visits. Opportunities to expand community ART distribution and refills will be explored.

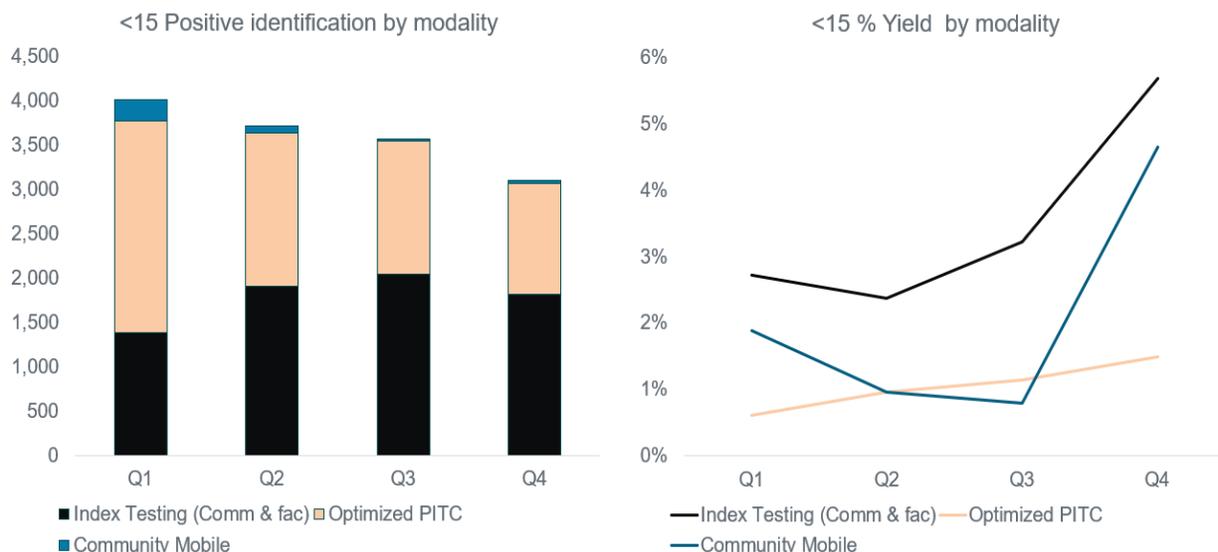
Adult women

ART coverage among women living with HIV who are age 25 years or older is over 81%. PEPFAR/T plans to continue to close remaining gaps in ART coverage in women through support for index testing by promoting more complete enumeration of sexual partners, including through engagement of expert clients (ECs) in index contact elicitation and notification. Based on recent data, ANC coverage is very high, with 99% of people visiting ANC for the first-time receiving HIV testing. The program will introduce HIVST for high-risk females in facility and community-based settings. As a mature and successful PMTCT testing program supported by PEPFAR/T, PEPFAR/T will begin transitioning PMTCT testing services to the GoT. PEPFAR/T will continue to improve counseling to promote retention in PMTCT through same-day and weekly tracking of clients to ensure they are linked and maintained on treatment, including regular updates of national tools, as well as, monthly, data driven, M&E patient follow-up status to achieve viral load suppression among beneficiaries of PMTCT. Furthermore, PEPFAR/T will strengthen and integrate viremic clinics in facilities with high volume clients to increase retention into care as well as adherence to treatment. Lastly, PEPFAR/T will continue to support family-centered approaches and GBV/IPV screening services as part of these testing activities.

Pediatrics

The 2019 program data show major gaps in identifying pediatric populations living with HIV despite increase in yield of HIV testing and viral suppression. The overall strategy for addressing the gap in ART coverage in pediatric populations has four elements: (1) improving EID coverage, (2) index testing for all biological children of mothers with HIV, (3) OVC activities, and (4) risk screening for children aged 10-14 years. Figure 4.1.5A shows the FY19 quarterly pediatric HIV case identification trend and yield by modality.

Fig 4.1.5A: Pediatric case finding by modality



In FY19 PEPFAR/T achieved 72% of EID testing coverage at two months, which is an increase from 64% in FY18. This is still below the target of 80% EID coverage for infants under two months of age. Despite this progressive improvement on EID coverage, there are still challenges to be addressed which include (1) low mother-infant pair retention, (2) mobility of pregnant women to seek support for delivery and post-partum period, (3) skilled staff turnover, (4) long turn-around times for dried blood spots (DBS) results, and (5) poor tracing of HIV-exposed infants (HEI) less than two months of age for DBS testing.

PEPFAR/T is working to ensure a systematic approach is used to identify all HEI through screening, use of immunization cards, and by ensuring an EID sample is collected at the first immunization visit. PEPFAR/T will continue to support local government authorities (LGAs) and IPs to ensure that all PMTCT sites are equipped to provide EID services and can utilize peer mothers to screen immunization cards to identify those eligible for testing and follow up mother-baby pairs. PEPFAR/T will also introduce local EID tracking registers at labor/delivery and ensure active communication between this department and the reproductive and child health clinic to report on the number of HEI live births for DBS collection. Use of mobile technology for sharing the HEI data will assist with follow-up. Furthermore, PEPFAR/T will scale-up the use of GeneXpert - near point of care (POC) - for EID testing to address challenges related to the long turn-around time and low coverage.

Currently, Tanzania is using DBS for EID testing on Genexpert machines, and staff facilities are trained for DBS collection and sample management. Available standard operating procedures and guidance are for DBS samples. Given that Same Genexpert machines are targeted for EID, TB and VL (special groups), increased workload is likely to happen at some of these testing sites. DBS is the best option for now to ensure sample quality in case testing may not happen on same day or in case these may need to be transported to another sites. mPIMA for EID testing are available in four sites. PEPFAR /T is working with MOH/NACP to address reported unreliable support for mPIMA even within the existing few sites with mPIMA . However, the program believes that with existing capacity within conventional and POCT test options will be able to support EID testing for the country. IPs will continue to support mentorship and

supervision on the use of the mother cohort register to improve EID data quality. In addition, PEPFAR/T will leverage the OVC platform to increase HEI referrals for EID.

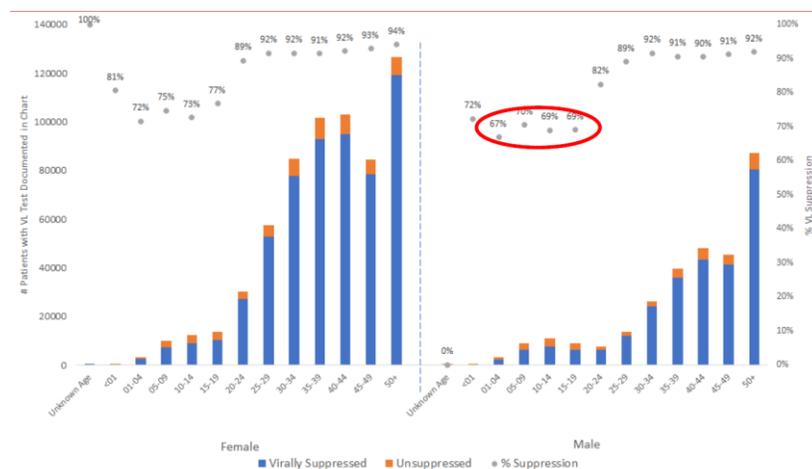
PEPFAR/T has scaled-up index testing and continues to strengthen index testing with fidelity. As part of COP20, PEPFAR/T will continue to ensure every biological children of HIV positive mothers in care, traced, and tested. The OVC program will be leveraged as an entry point for identifying and testing children most at risk after being screened for eligibility. OVC community case managers will support linkages from the community to the facility through escort referrals and track clients that are lost to follow up.

PEPFAR/T will enhance optimized PITC at inpatient, TB, and malnutrition wards and increase the use of risk screening tools in outpatient for 10-14-year-olds children and follow the mother's risk and testing status for children under ten. PEPFAR/T will strengthen pediatric and adolescent friendly services to improve retention and viral suppression. In addition, viremia clinics will be conducted to address challenges regarding unsuppressed children.

Viral suppression is another key area of focus for children and adolescents. FY19 program data that show lower viral suppression among children aged 0-14 years, especially among male children (Figure 4.1.5B). In addition to implementing approaches to improve ART coverage among this group, PEPFAR/T expanded the use of age/weight appropriate dosing charts, including providing advocacy and roll out support to the GoT during the TLD transition for children weighing >30 kg. PEPFAR/T has also worked with GoT on a plan to phase out Nevirapine (NVP) and efavirenz (EFV)-based regimens. The GoT introduced Lopinavir granules based on a quantification completed by mid-2019. Currently, PEPFAR/T and GoT are accelerating the transition of optimal regimens for children. Between FY19 Q1 and FY20 Q1, Tanzania decreased NVP based regimen from 58% to 33%, and EFV-based regimen from 30% to 20%, while dolutegravir (DTG) based regimen increased from 0% to 25%, and Lopinavir syrup from 11% to 18%.

Strengthening site mentorship will be included to ensure HCWs understand and are competent in ART dose adjustment and transitioning to optimal regimens. To improve viral suppression, PEPFAR/T will also conduct site-level analyses to assess adolescents and children for timely identification of non-suppressed individuals and ultimately fast track enhanced adherence counseling and regimen changes to pediatric and adolescent clients.

Figure 4.1.5B: FY19 Q1 – FY20 Q1 transition to optimal regimens for children



Focusing on cities with high burden

PEPFAR/T will increase the quality and coverage of HIV testing and care and treatment services in high burden cities as essential activities to reach epidemic control. Based on 2020 PLHIV estimate used for COP20 planning, seven metropolitan centers (Mwanza, Tanga, Geita, Tabora, Mbeya, Dar es Salaam and Njombe) were found to have high HIV burdens. Four of these cities – Dar es Salaam, Mwanza, Mbeya, and Tabora – are currently the focus during FY20 for PEPFAR/T will scale-up the package of identification activities described earlier. Targeted community testing approaches will be implemented in all seven of these cities, where testing after screening will be implemented to reach KVPs including: fisher-folks, truck drivers, miners, sex workers and their clients, ‘Bodaboda’ drivers, and other mobile populations that play an important role in HIV transmission within cities. Sexual network tracing (social network testing) will be used to enhance standard index testing in these cities. PEPFAR/T will improve linkages to ART and retention by strengthening linkage and case management, as is being done throughout the country.

TB Screening with fidelity and Isoniazid preventive therapy coverage

Despite high reported coverage of TB screening (99.5%) among PLHIV, program data show low numbers of people with HIV who screen positive (42,387), and low numbers of people diagnosed with TB (9,785). To address this, PEPFAR/T will strengthen TB screening with fidelity for case detection by focusing on screening quality improvement (QI) measures, on the job training for health care workers, close partner management on TB management, and involve local government for close monitoring and follow-up. Additionally, the screening that is used prior to HIV testing includes screening for TB symptoms. This allows for an integrated approach to HIV and TB screening. Whenever a person is identified with TB symptoms, that person will receive both HIV testing and TB testing (using the GenXpert MTB/Rif Assay). PEPFAR/T will also optimize the use of GeneXpert machines for TB diagnosis among PLHIV by ensuring the availability of cartridges and intensifying mentorship on the use of the machines.

Additionally, high rates of screening did not translate to high coverage of TB prevention. IPT coverage increased 9% (FY17) to 45% (FY19), and IPT completion increased from 33% (FY2017) to 84% (FY19). Coverage was low due to an inadequate supply of isonicotinylhydrazide (INH) at the site level in FY19 Q2-Q4. PEPFAR/T is working with the Ministry of Health to ensure improved availability of INH at the site level.

PEPFAR/T aims to achieve 100% IPT coverage of all eligible clients during COP20. To achieve this, PEPFAR/T is working in close collaboration with the government (NACP, NTLP and PO-RALG) to ensure a reliable supply of Isoniazid to increase the number of clients enrolled in and completing IPT. PEPFAR/T implementing partners will follow up on IPT implementation through regular supervision, on the job training, and mentorship to health care providers. PEPFAR/T is also working to improve data collection through the care and treatment centers (CTC) databases to ensure IPT provision is documented and monitored.

4.2 Retaining clients on treatment and ensuring viral suppression

During FY19, PEPFAR/T had a 12-month retention rate of 94.7% among established clients and a 12-month retention rate of 90.8% among new clients. Retention in both these groups has shown a consistent upward trend beginning in FY19 Q2. This improvement is the result of concerted efforts outlined in COP19 to address challenges with retention. Moving forward, specific changes to be introduced include scaling up successful strategies to all PEPFAR supported facilities in Tanzania and ensuring a client-centered approach that creates a welcoming clinical environment.

PEPFAR/T Retention Response

All sites:

- Appointment reminders
- Multi-month dispensing for eligible clients
- Same day tracking for missed appointments
- Enhanced community tracking through facility-community collaboration
- Site level indicators to improve appointment adherence and reduce recent loss
- Extend linkage case management beyond the routine 6 weeks for high-risk groups

To address retention among new clients, PEPFAR/T will continue to implement the LCM and will explore extending LCM beyond the routine six-week period for specific at-risk populations (i.e., adults 20-29 years old). Sites now have access to a newly implemented electronic pharmacy system to track and record clients who attend for fast-track pharmacy pick-ups or in-transit refills at another facility – this will lead to more accurate reporting of clients currently on ART. Additional systems improvements, including the unique identification strategy, will help eliminate double counting of individuals who anonymously register more than once.

PEPFAR/T and GoT currently support multi-month dispensing to reduce costs and service waiting times to clients. Interruptions in TLD supply chain plans interfered with scale-up of six-month multi-month dispensing. Experiences gained from the initial implementation in Dar es Salaam region will allow swift implementation throughout the country upon receiving the required stocks.

Clients identified to have challenges in adherence to treatment, retention in care, and/or attaining viral suppression receive the necessary attention through designated days where the clinic is focused to address group and individual issues through enhanced adherence counseling coupled with peer support. These designated clinic days, coupled with greater frequency of visits, offer service providers the space they need to focus on special needs in order to identify and address unique, individual barriers in the spirit of client-centered care.

For adolescents and children, PEPFAR/T will strengthen pediatric and adolescent friendly health services (AFHS) to address adolescents' needs and to promote retention. AFHS, including adolescent/teen clubs and peer treatment support groups, will be strengthened to reach more adolescents for HIV prevention and will include components addressing poor viral suppression, such as adherence counselling and ART regimen optimization. There will be tailored support to adolescents as they transition to adult care and treatment. Older adolescents participate in peer group sessions to share experiences during the transition to adult care. Health facility staff and community case workers provide enhanced monitoring and adherence support to adolescents experiencing challenges adapting to adult services. Where necessary these case workers also escort adolescents to clinic appointments. Health facility staff provide disclosure counseling to adolescents, which is reinforced through psychosocial support that community case workers provide in the home.

To ensure viral suppression, PEPFAR/T will continue to support tracking of quality of care indicators, supply chain management, and transition to optimized treatment regimens. PEPFAR/T will assist GoT in exploring point-of-care viral load to mitigate logistical challenges associated with hard-to-reach areas and long distances between facilities and testing laboratories.

PEPFAR/T will ensure accountability through real-time monitoring of monthly performance at the site level. The PEPFAR/T monthly indicators include retention and viral load suppression (among the priority indicators) for enhanced partner management. Through continuous quality improvement efforts, sites (with support from PEPFAR/T and local government) identify root causes contributing to losses or virologic failure and introduce changes that are tailored to the needs of individual clients. For retention, activities at the site level will continue to focus on improving capture of information needed to track patients, methods of attempting contact, and outcomes of each attempt. Additionally, monitoring of client experiences and quarterly reporting of findings through the community-led monitoring platform will further inform the development and implementation of workable solutions to improve retention and viral load suppression.

4.3 Prevention, specifically detailing programs for priority programming

a. HIV prevention and risk avoidance for AGYW and OVC

In Tanzania, there are 6.2 million AGYW age 15-24 and, according to the THIS, this population is at considerable risk for contracting HIV. A variety of factors – including harmful social and gender norms, lack of education, and GBV – mean that adolescent girls are more than twice as likely as their male counterparts to become infected.

Since 2015, PEPFAR/T has intensified efforts to avert new infections among AGYW and OVC by specifically targeting them within the broader key and vulnerable populations' portfolio, and more specifically through the DREAMS initiative. DREAMS delivers a comprehensive set of evidence-based age-appropriate biomedical, behavioral, and structural interventions that have been proven to reduce the risk of HIV in AGYW. These efforts include expanding and deepening coverage within the existing priority councils by saturating priority geographic areas and population groups with combination prevention interventions, ensuring targeted testing with improved testing yields for AGYW and reaching the most vulnerable girls.

To ensure young women are identified and offered a core package of services at the community and facility levels, the Tanzania DREAMS program leverages the capacity of key partners for OVC, community prevention, and facility-based interventions. Primary beneficiaries are targeted through OVC programming (age 9-14), intensive peer and community-based outreach (age 15-24), and by adolescent friendly-trained health providers at health facilities. Once identified, a vulnerability assessment (i.e., vAGYW index) is used to understand the level of risk of the beneficiary and guide the prioritization of services. Beneficiaries are split into three distinct age categories: 9-14-year-olds; 15-19 year; and 20-24-year-olds. Girls are maintained in the program until they meet the established program completion criteria which typically takes about 9-18 months.

By the end of FY 21, it is expected that 91,919 new AGYW (age 10-24) will be reached with DREAMS primary interventions. These targets represent newly enrolled DREAMS girls, rollover girls who will be active but have not completed the program at Q4 and maintenance targets for saturated age bands. Approximately 70% of the total AGYW reached will also receive appropriate secondary interventions. The table below summarizes the DREAMS primary and secondary interventions:

Age Disaggregates	9–14	15–19	20–24
Population Description	OVC in- and out-of-school, lifetime experience of sexual violence, experience of physical/emotional violence in the past 12 months, history of sexual activity, alcohol use	Irregular condom use and multiple sex partners in the past 12 months; history of STIs, pregnancy, or transactional sex; lifetime experience of sexual violence; orphanhood; or out-of-school (never enrolled or dropped out); alcohol misuse	Irregular condom use and multiple sex partners in the past 12 months; history of STIs, pregnancy, or transactional sex; lifetime experience of sexual violence; alcohol misuse
Proportion of the Vulnerable Population*	50%	40-60%	65-85%
Primary Individual Interventions	<ul style="list-style-type: none"> Education subsidies HURU kits and curriculum (+ new modules on sexual violence prevention for 9-14-year-olds) 	<ul style="list-style-type: none"> HTS Condom provision Community-based HIV and GBV prevention (Stepping Stones) Combination socio-economic approaches (Worth+ for all and enhanced economic strengthening package for most-at-risk) 	<ul style="list-style-type: none"> HTS Condom provision Community-based HIV and GBV prevention (Stepping Stones) Combination socio-economic approaches (Worth+ for all and enhanced economic strengthening package for most-at-risk)
Secondary Individual Interventions	<ul style="list-style-type: none"> Referrals to, or if clinical partner, provision of post-violence care Parenting and care giver programming (<i>Furaha</i>) 	<ul style="list-style-type: none"> Contraceptive method mix Parenting and care giver programming for AGYW 15-17 years (Sinovuyo) Referrals for biomedical services PrEP Referrals to, or if clinical partner, provision of post-violence care 	<ul style="list-style-type: none"> Contraceptive method mix Referrals for biomedical services PrEP Referrals to, or if clinical partner, provision of post-violence care
Contextual Interventions	Influential men and women (all ages)		
	<ul style="list-style-type: none"> Community mobilization and norms change using SASA! Package Leverage DREAMS and OVC program to implement justice for children activities introduced through COP 19 Faith Community Initiative funds. 		<ul style="list-style-type: none"> SASA! package does not target AGYW directly but rather general and adult influencers at the interpersonal and community levels Index testing will be offered for male sexual partners of AGYW who test positive

The layering table will be changed and adapted in COP20. In COP19, the OVC program began implementing new modules on sexual violence and prevention for 9-14-year-old girls and boys into the *HURU* curriculum which focuses on menstrual hygiene management, reproductive health (RH), risk avoidance, and GBV prevention alongside a complementary parenting program, *Furaha*. In COP20, the complementary parenting program will move from a primary package intervention to the secondary package.

There will be changes in the economic empowerment activities for the upper two age bands. WORTH+ will still be offered to all DREAMS girls aged 15-19 and 20-24, and AGYW will also

receive a start-up asset and/or matched funds. The start-up asset will be delivered after girls complete the WORHT+ curriculum and are starting their individual enterprises, and matched funds will be delivered after one year in order to help AGYW scale and expand their businesses. These additions will strengthen the AGYW's capacity to create sustainable businesses for consistent income.

A robust M&E system, the DREAMS Auxiliary M&E System (DAMES) is in place to assure DREAMS girls are receiving the primary packages as intended and relevant to her need. DAMES tracks each individual girl across the package of services using a unique identifying code. This increases PEPFAR/T's ability to provide programmatic oversight and assure the program is being implemented with fidelity across all partners. It provides a routine and standardize way for the partners and the interagency team track the layering of services at an aggregate level. In COP20 the DAMES system will be integrated to all community partners and improvements in the dashboard functionality will be made. Once integration is complete, PEPFAR/T expects the DAMES implementing partner to provide only maintenance of this system. Long term, PEPFAR-TZ will work with the MOH to adapt DAMES into the government system and introduce it in the facilities.

In order to assess DREAMS reach, inform programming for potential expansion and utilizing funds in the most efficient way, the DREAMS team estimated the number of vulnerable girls in each SNU. THIS/DHS data were used to estimate the number of vulnerable girls in each DREAMS SNU. For the 10-14 age group vulnerability estimates are based on national level estimates of the percent of those out of school, married/sexually active before 15, or orphans. Regional level estimates of ever engaging in condom less sex or multiple sex partners in the past year were used to estimate the proportion of vulnerable AGYW aged 15-19 years in each district, and the results range from 43-58%. Regional level estimates of ever engaging in condomless sex or compensated sex in the past year were used to estimate the proportion of vulnerable AGYW aged 20-24 years, and the results ranged from 66% to 88%. Saturation denominators showed strong coverage in three of the operating SNUS, allowing the program the option to extend to new councils. The following table includes estimates of vulnerable girls from the original 8 SNUs and the 3 expansion councils agreed upon with OGAC, HQ counterparts, DREAMS-TZ and partners. These new councils are Nyamagana DC, Mufundi DC, and Mbarali DC.

Council	Age	HIV- Population	% Vulnerable	Number Vulnerable	75% Vulnerable (Saturation Target)
Kahama TC	10-14	21265	50%	10633	7975
Kyela DC	10-14	16575	50%	8287	6215
Mbeya CC	10-14	27824	50%	13912	10434
Msalala DC	10-14	23398	50%	11699	8774
Muleba DC	10-14	48052	50%	24026	18019
Shinyanga DC	10-14	31137	50%	15569	11676
Shinyanga MC	10-14	14215	50%	7107	5331
Ushetu DC	10-14	25874	50%	12937	9703
Mbarali, DC	10-14	24201	50%	12100	9,075
Nyamagana, DC	10-14	34464	50%	17232	12924
Mufundi, DC	10-14	21831	50%	10918	8188
Kahama TC	15-19	19025	58%	10978	8233
Kyela	15-19	14680	43%	6356	4767
Mbeya CC	15-19	31419	43%	13604	10203
Msalala	15-19	18188	58%	10495	7871
Muleba DC	15-19	38861	44%	17216	12912
Shinyanga DC	15-19	22824	58%	13169	9877
Shinyanga MC	15-19	12774	58%	7371	5528
Ushetu	15-19	18950	58%	10934	8200
Mbarali, DC	15-19	20137-	43%	19737	14802
Nyamagana, DC	15-19	38864	46%	17,877	13,408
Mufundi, DC	15-19	14056	49%	5622	4,216
Kahama TC	20-24	29123	84%	24464	18348
Kyela	20-24	16248	73%	11861	8896
Mbeya CC	20-24	13940	73%	10177	7632
Msalala	20-24	17417	73%	12714	9536
Muleba DC	20-24	10851	73%	7922	5941
Shinyanga DC	20-24	13972	73%	10200	7650
Shinyanga MC	20-24	11534	66%	7613	5709
Ushetu	20-24	29496	66%	19468	14601
Mbarali, DC	20-24	16041	66%	10587	7940
Nyamagana, DC	20-24	31831	66%	21008	15,756
Mufundi, DC	20-24	10,493	69%	6296	5430

In COP20, DREAMS will increase coverage in new and expansion SNUs by targeting 91,919 (27,608 rollover) vAGYW and their sexual partners, and all non-military OVC targets will be streamlined to the primary OVC partner. All DREAMS girls will access HIV testing as part of a core package of services to increase knowledge of their serostatus. HIV testing will promote prevention and facilitate earlier linkage of HIV-positive girls to care, ART, and index testing for sexual partners. Since COP18 PEPFAR/T DREAMS Implementing Partners have been ensuring health providers are trained on SOPs, job aides, elicitation and screening tools to ensure index testing is implemented with appropriate quality and fidelity; possible violence is minimized; and different approaches are used to notify partners who pose a risk for intimate partner's violence.

For an SNU to be classified as saturated it must reach at least 75% of vulnerable population in each of the three age categories targeted in DREAMS (10-14, 15-19 and 20-14). In COP19

PEPFAR/T estimated the number of vulnerable AGYW in each SNU. The table below highlights saturation targets for each DREAMS SNU (by age band).

DREAMS Councils	Target Type	Targets (9-24 Combined)
Kahama TC	Rollover*+ New**+Maintenance***	17910
Kyela DC	Rollover+ New	7309
Mbeya CC	Rollover + New + Maintenance	10803
Msalala DC	Rollover + New	9561
Muleba DC	Rollover + New + Maintenance	17908
Shinyanga DC	Rollover + New	11930
Shinyanga MC	Rollover + New	6216
Ushetu DC	Rollover+ New	10282
Nyamagana DC	New 7800	7800
Mufindi DC	New 5900	5900
Mkarati DC	New 10800	10800

* Rollover: Beneficiaries enrolled in the program in FY20 and completing in FY21

** New: Newly enrolled beneficiaries for FY21, expected to complete in FY22

***Maintenance: New girls in councils that are saturated for a specific age band

DREAMS reaches the most vulnerable AGYW who may have increased susceptibility to experiencing violence. To help connect those experiencing different forms of violence to available resources and support in the community, in COP20 Implementing Partners staff involved in direct service delivery will also be trained on how to enquire about violence and offer first line support (LIVES) in response to disclosures of violence. To strengthen linkages among AGYW, PEPFAR/T will ensure those who are HIV-positive are attached to expert patients and community-based service providers for escorting to facilities of their choice and tracing (in case of unsuccessful linkage at first encounter). Linkages will be tracked on a weekly basis at facilities to determine immediate intervention needs. PEPFAR/T will also significantly scale-up PrEP among vAGYW to support them to take control of their sexual health and reduce their HIV risk. There will also be an enhanced focus on reaching and improving access to services for both men and women under 30 and community members being reached through evidence-based gender norms interventions, including SASA!

On average, AGYW age 15-19 and 20-24 receive at least five services, including: HTS, social and behavior change (SBC) interventions, GBV screening, socio-economic strengthening, and better parenting interventions. Community-based mobile health units provide a one-stop suite of services including HIV testing, Family Planning (FP), screening for gender-based violence (GBV), TB, and substance/alcohol use, and escorted GBV referrals. Layering data reveal a need to improve FP commodity availability to ensure AGYW have consistent access to contraceptive the methods in a timely manner.

In COP20, PEPFAR/T will continue to assist the GOT to adopt a total market approach for condoms by directly supporting the social marketing sector, which complements GFATM support for male and female condoms distributed within the public sector. Support for condom programming will remain national in scope, with condom promotion activities limited to scale-up councils where targets are set for comprehensive prevention interventions. PEPFAR/T will work with a local social marketing organization to gradually transition its socially marketed branded condoms to become self-sustaining by leveraging their program income.

DREAMS provides PEPFAR/T with a platform to enable GOT structures to better coordinate adolescent health activities at the council level across key sectors (health, education, livelihoods, etc.) for improved service uptake and health outcomes. In the eleven councils with new DREAMS targets, PEPFAR/T will work with the TACAIDS to ensure effective coordination of AGYW activities at national and sub-national levels and smooth implementation of DREAMS interventions. The PO-RALG will specifically generate and utilize improved age- and sex-disaggregated data, including for HIV and health, to inform budget development and decision making related to AGYW interventions at the sub-national level. This includes strengthening adolescent participation in local governance and sensitization of communities on priorities of adolescents and young people.

According to the 2016-17 Tanzania DHS (TDHS), 27% of girls age 15-19 have begun childbearing. These statistics are even higher in some regions where DREAMS is being implemented such as Shinyanga (34%) and Mbeya (33%). Harmful social and gender norms and lack of RH knowledge are just two of many factors that contribute to such high rates of pregnancy among young girls. Tanzania's DHS further indicates that knowledge of FP is inadequate, with 43% of young women age 15-24 unaware of any modern contraceptive method. For those who have not completed primary school, knowledge and use are even more limited, with only 9% uptake of modern FP in this group. Tanzania also has one of the highest child marriage rates in the world. On average, almost two out of five girls will be married before their 18th birthday (TDHS 2015-16). While the Law of the Child is in place, stating that a child is a child until 18, the customary marriage law enables a young woman to be married at age 15.

DREAMS addresses some of the key drivers of teen pregnancy and early marriage through behavioral and structural interventions including: support for continued education; puberty and body awareness education; FP and RH education and services; sexual violence prevention; and parent and community sensitization on the effects of harmful social and gender norms.

While the 2015-16 TDHS has regional data on teen pregnancy and early marriage, there is not currently a systematic routine way to collect district-level data on these indicators. As a result, many regions and districts have put in place mandatory pregnancy testing that includes physical examination of AGYW and/or urine pregnancy tests. If a female is found to be pregnant, she is immediately dismissed from school and not allowed to return. In COP20, PEPFAR/T will continue to work with the MoHCDGEC and PO-RALG to identify more constructive and sustainable ways to track these key statistics within the current data collection modalities. Political support will be critical to address the legal and cultural barriers to reduce teenage pregnancy and early marriage. It is important to note, however, that the current political environment penalizes AGYW who become pregnant by systematically blocking them from accessing opportunities to pursue formal studies, thus limiting PEPFAR/T's impact.

Tanzania has 2.3 million OVC affected by HIV (MEASURE Evaluation, 2018). There are an estimated 78,091 children and adolescents living with HIV (C/ALHIV) who are on ART in 81 priority PEPFAR councils where the OVC program is implemented. The violence against children (VAC) study conducted in Tanzania (2009) showed that more than one-third (33%) of girls experience sexual violence. Early sexual debut is associated with exposure to violence, and childhood sexual violence is associated with increases in young adults' sexual risk behaviors. The goal of the OVC program is to prevent new HIV infections among at-risk OVC (in collaboration with DREAMS) and improve OVC and family well-being through improved access to and utilization of HIV/health, nutrition, education, protection, psychosocial, and economic strengthening services. The program contributes to the goal of HIV epidemic control

by contributing to prevention of new HIV infections among children, adolescents, and young women; ensuring that all OVC know their HIV status or have been assessed for HIV risk; and ensuring that newly identified C/ALHIV are immediately linked to treatment and provided retention and adherence support; this contributes to reducing the pediatric treatment gap. In addition, OVC programming supports children and caregivers who are living with HIV through HIV-inclusive case management. OVC case workers help monitor child and caregiver retention and adherence, provide treatment literacy, and reinforce age-appropriate and positive family disclosure. Preventing and responding to sexual violence is an OVC program priority. The OVC National Costed Plan of Action (NCPA) and National Action Plan to End Violence against Women and Children 2017-2022 guide the implementation of OVC programming in Tanzania.

As of Q1 of FY20, the OVC program has enrolled 22,209 (28%) of C/ALHIV on ART in OVC SNUs. By Q4 of FY20, the program is expected to enroll 38,777 (50%) of C/ALHIV on ART. 98% of children have known HIV status documented in their case file. PEPFAR/T trained 32 staff from 15 organizations working with children in Tanzania on Child Safeguarding. In addition, OVC implementers have conducted three dialogues with faith community and community leaders on topics related to prevention of sexual violence (with a focus on 9-14-year-old girls and boys) and ensuring justice for children. The OVC program has translated and integrated the three S/GAG modules (Healthy and Unhealthy Relationships, Making Decisions About Sex, and Sexual Consent) into the HURU program. The program is working to adapt sexual violence against children (SVAC) 101 materials and conduct a training of trainers for implementing partners working with children in FY20 Q2. Collaboration between OVC implementing partners, religious leaders, faith community, and other partners working in the community and facility have further enhanced opportunities for the OVC program to improve HIV case identification, treatment linkage, retention and viral suppression. The signing of memoranda of understandings (MoUs) between OVC and clinical partners has proved to be effective in identifying C/ALHIV for OVC program enrollment and linking them to HIV services.

In COP20, the PEPFAR/T OVC program will intensify its focus on prevention of HIV infection among children, reducing the pediatric HIV treatment gap, tracking viral load results and suppression for all enrolled C/ALHIV (in collaboration with clinical partners), addressing high rates of sexual violence among adolescents, and mitigating the risks faced by children of parents/caregivers with poor adherence to ART. The program will use an intergenerational approach to risk and resilience to serve 587,688 OVC under age 18 from 81 priority councils under the flagship OVC program Kizazi Kipya (of which 78,740 will be DREAMS AGYW 10-14 years). In addition, an estimated 70,852 DREAMS AGYW 15-17 years will be OVC_SERV beneficiaries. This brings the PEPFAR/T total OVC_SERV<18 target to 658,889. Females comprise 60% of the COP20 < 18 years targets. OVC aged 10-14 accounts for 36% of <18 targets OVC aged 15-17 accounts for 27%. PEPFAR/T will also reach 204,299 OVC caregivers in the Kizazi Kipya program. The 791,987 target is distributed into OVC comprehensive targets of 587,688 (74%); OVC preventive targets of 80,300 (13%) for boys and girls aged 9-14 years in high HIV burden SNUs; and DREAMS OVC_SERV 10-17 years targets of 93,037 (16%).

PEPFAR/T will adapt the stability benchmark for graduation that will allow more children to graduate from the OVC program. This will create space to enroll C/ALHIV on ART into the OVC program. Recruitment of OVC into the comprehensive program will happen at ANC/PMTCT and CTC facilities. The purpose is to identify vulnerable children newly enrolled on treatment, infants of adolescent mothers who are lost-to-follow up in PMTCT, biological children of index adult clients, and other asymptomatic but undiagnosed children. Community-based case identification will prioritize OVC and adolescents who are highly vulnerable to HIV infection, particularly

adolescent girls and children who have experienced violence. The OVC preventive program will target girls and boys 9-14 years in high burden SNU using a school-based platform.

The service package for a comprehensive program for children 0-9 years includes, among others: HIV risk assessment and referral to HTS; accompaniment for linkage to treatment; ART adherence and disclosure support; educational subsidies; Community Health Fund cards; parenting support; economic strengthening village savings and loan associations and start-up kits for caregivers of CLHIV; nutritional assessment, counseling and support; and birth and insurance registration.

In COP20, the service package for OVC aged 9-14 will include: *"Furaha"* (translated Sinovuyo) for parenting and violence prevention; HURU in school HIV prevention plus S/GAC modules: *Health and Unhealthy relationships, Making Decisions about Sex, and Sexual Consent*; and education support and monitoring of school progression. Specific activities include prevention of forced, coerced, or non-consensual sex; linkage to post-GBV care and ensuring justice for children; IMPOWER, and Coaching Boys into Men (CBIM). The service package for children aged 15-17 will include: *"Furaha"* parenting and violence prevention; adolescent sexual and reproductive health education; and education subsidy support and monitoring of school attendance and progression.

The OVC program will provide case management for all children and caregivers in the comprehensive program, including HIV risk assessment; treatment literacy; and VAC & GBV screening and referrals to comprehensive services. Other services delivered via case management include adherence support; active referral and linkages to HTS, CTC, and post GBV care, justice for children, health and social protection; and family re-unification and support for at-risk street children.

DREAMS interventions are integrated within the OVC program and implemented as part of the OVC package in DREAMS' SNU. The program integrates sexual violence messages into interventions for parents and caregivers. Emphasis will be given to ensuring that all programs dealing with children continue to implement and reinforce child safeguarding policies and procedures to prevent VAC and GBV.

Faith-based organizations are key partners in addressing GBV/VAC and the stigma that often prevents children and adolescents from accessing HIV services. PEPFAR/T will continue partnering with religious leaders and faith communities to develop and disseminate messages on the prevention of sexual violence throughout their network.

In COP20, PEPFAR/T will ensure 100% of OVC active in the program have knowledge of their HIV status and have their HIV status documented in their case file. The OVC program will continue to use the OVC HIV risk assessment tool which has proven effective in targeting children at risk of HIV. Four questions in the risk assessment tool have shown potential to identify more HIV-positive children. These questions include asking whether: there is one or more PLHIV in the household (24% of these children are HIV-positive); one or both biological parents of the child are deceased (12%); a child is living with a chronically ill caregiver (7%); and the child has ever been admitted to the hospital (6%). Further refining these questions to make the HIV screening tool more HIV-sensitive is ongoing. PEPFAR/T will continue to conduct HIV risk assessments for all OVC with undocumented HIV status and document whether testing is not indicated or refer those at-risk for HTS (providing accompaniment by case workers, as needed). PEPFAR/T will also continue to strengthen and mobilize testing of biological children of HIV-positive clients (ensuring systematic assessment of 100% of HIV+ mothers and their

children, in collaboration with clinical partners, for potential enrollment in OVC programming), particularly adolescent breastfeeding HIV-positive women, and scale-up testing children of HIV-positive FSW and women who inject drugs.

To sustain the OVC response, community ownership will play a critical role; therefore, caregiver strengthening will continue to be an important component of the OVC service package. Other key activities to strengthen OVC service delivery and bi-directional linkages will include community case manager training, capacity strengthening of LGAs, and community child protection committees. Continuous robust partner management, program monitoring, quality improvement, learning, adaptation, and operational research will all be employed to advance the evidence base on HIV risk and reduction among underserved OVC sub-populations.

To improve the pediatric continuum of care and prevention of new infections among children, the program will continue to scale-up, learn from, and adapt best practices that strengthen linkages across HIV services. Effective interventions to improve linkages among OVC and adolescents will include flexible clinical hours, peer support and adherence clubs, adherence monitoring, and family disclosure support. MOUs between PEPFAR/T OVC, clinical, and the PO-RALG will continue to be used to designate the roles of facility healthcare workers and community case workers, as these have demonstrated effectiveness in tracking HIV-exposed and HIV-positive children who are lost to follow-up or missed appointments at facilities, and linking them back to care and treatment. MOUs will address critical issues related to referral protocols, case conferencing, shared confidentiality, and joint case identification. Moreover, active referrals such as accompaniment by case workers to HTS and ART sites have been critical to improving referral to service completion by over 90%. PEPFAR/T will scale-up these proven interventions across the OVC scale-up SNUs. The OVC partners will also collaborate with demand creation programs to generate demand and increase uptake of HIV services among ALHIV and on delivering key messages to prevent sexual violence.

b. Children/PMTCT

PEPFAR/T is working to substantially improve service delivery for children, especially EID at two months, case identification and viral suppression for children. Despite progress made in treatment growth, program data show major gaps in identifying, retaining, and virally suppressing pediatric populations. PEPFAR/T achieved 104% of the annual target for EID, with only 72% of HEI being tested for HIV by the age of two months. Based on FY19 results, 60,098 pregnant women tested positive for HIV, and 54,916 HEI were tested at 12 months. Of the 54,916 HEI, 1,197 (2.2%) tested HIV-positive, and 1,037 (86.6%) were initiated on ART. Challenges contributing to this gap include poor quality of DBS samples leading to high rejection rate at the lab, poor retention of mother-baby pairs, missed opportunities to enroll in the OVC program and receive support, especially adolescents and young mothers, and sub-optimal use of peer mothers to monitor and track clients lost to follow-up.

PEPFAR/T will continue to support LGAs and partners to ensure that all PMTCT sites receive capacity building on DBS collection, storage and packaging through onsite group mentorship, identification of a DBS quality focal person at each site, and joint supportive supervision with regional and community health management teams across poor performing facilities. PEPFAR/T has also commissioned the Mother2Mother program to support MOH to develop a mother-mentor model to address stigma and community-based issues that lead to poor retention of mother-baby pairs. Furthermore, PEPFAR/T will scale-up the use of GeneXpert – near point-of-care (POC) – for EID testing to address challenges related to the long turnaround time and low EID coverage. Partners will continue to support mentorship and supervision on

the use of the mother cohort register to improve EID data quality. In addition, PEPFAR/T will leverage the OVC platform to improve HEI referrals for EID and enroll mother-baby pairs for improved retention.

In COP20, PEPFAR/T will continue to scale up index testing as a key intervention to identify CLHIV. Through its “maximizing index testing” approach, PEPFAR/T will ensure all biological children of HIV-positive women are offered the opportunity to test and be linked to treatment. In doing this, PEPFAR/T will ensure standards of safety and confidentiality are adhered to through a structured mechanism. Optimized PITC will be modified to address findings from the validation of the HIV screening tool. All children below ten years old attending high yield entry points will be tested without screening and children above ten years old, including adolescents, will be screened for HIV testing. PEPFAR/T will strengthen pediatric and AFHS to improve retention and viral suppression. Viremia clinics will also include OVC case workers to address social economic challenges regarding unsuppressed children and ensure they are enrolled into the OVC program for support.

Viral suppression is another key area of focus for C/ALHIV on ART. Despite improvement in both viral load testing coverage and suppression, FY19 program data show 71% viral suppression among children age 0-14, which is below UNAIDS and PEPFAR target of 90%. In addition to implementing approaches to improve ART coverage among this group, PEPFAR/T is working to support GoT in transitioning out suboptimal pediatric regimens, including NVP based regimens. PEPFAR/T has supported introduction of lopinavir granules use for young children and DTG for children weighing above 20kg and will continue to support rollout throughout the country. Site mentorship will be included to ensure service providers understand and are competent in ART dose adjustment and transitioning of regimens. To improve viral suppression, PEPFAR/T will also conduct site-level cascade analyses for timely identification of non-suppressed individuals and ultimately fast-track enhanced adherence counseling to C/ALHIV on ART.

C. Key Populations

PEPFAR/T provides targeted interventions for KP and priority populations (PP), including female sex workers (FSW), men who have sex with men (MSM), transgender people, people who inject drugs (PWID), and at-risk individuals within these sexual networks. Activities reaching KP are implemented in all 98 scale-up councils, eleven attained councils, and nine selected sustained councils with known hotspots. In COP20, these councils account for 84%, 12%, and, 4% of KP_PREV targets, respectively.

Cumulatively for FY19, implementing partners reached 232,235 KP/PP with the core intervention package, which was 81% of the annual target. A total of 220,369 (94.8%) clients were tested for HIV during the FY19 reporting period, 32,602 (14.79%) were identified positive, and 29,252 (89.7%) were documented as linked to ART. While some of these “unlinked” persons may be clients who came for testing a second or third time without reporting prior knowledge of status, efforts are still needed to maximize linkage. PEPFAR/T will do so through utilizing proven best practices such as linkage case management, a strategy used to increase linkages to treatment, disclosure and adherence. This has proved to be effective through the Bukoba Combination Prevention Evaluation.

In FY19 Q2, index testing has been one of the main contributors to identify positives among KP. The temporary ban on index testing that was instituted in December 2019 has had an impact on the identification and yield among KP. At the time that this document was drafted, the

PEPFAR/T team was in discussion with CSOs representing KP to address concerns raised around index testing practices and identify areas to further improve the quality of service delivery. After these important steps are taken, services may resume. Currently PEPFAR/T has indicators to track IPV on index testing services among KP.

In FY20, PEPFAR/T, in collaboration with GoT, has started the roll-out of recency testing to all testing points with the aim to understand the trends and sources of new HIV infections. This will help to identify new KP hot spots for prompt identification, enrollment, and monitoring.

FY19 data show low linkages to ART services for HIV-positive KP in councils that did not implement community ART. It has been observed that community enrollment and ART initiation of KP at the point of diagnosis greatly reduce barriers to enrollment in care. Data indicate initiation and linkage rates have continued to increase from 81 % in FY19 Q1 to 93% in FY20 Q1 among KP in councils with community ART. In COP20, with MOHCDGEC guidance, PEPFAR/T will continue scaling up ART provision in the community with fidelity to all councils as an important addition to the community-based KP package of services to maximize early linkage and retention to HIV care for newly diagnosed KP/PP clients.

In COP19, there has been significant improvement of the national KP program in Tanzania due to recognition by the GoT of the importance of providing a comprehensive prevention, care, and treatment package for KP. PrEP services are among the key components of this package. PrEP has been prioritized for groups of people who have substantial risk of acquiring HIV: serodiscordant couples; AGYWs; pregnant and breastfeeding women; MSM; transgender individuals; sex workers; and PWID. The national PrEP program will provide a comprehensive set of services in line with GoT guidelines and circulars. The program will provide flexibility for clients to choose and be supported in the use of other prevention strategies. Clients will be counseled at PrEP initiation and can choose to discontinue PrEP after starting, though retention activities will aim to minimize client loss. The HIV-negative individuals reached through index and community testing will be linked to PrEP as part of the prevention cascade. In FY19, a total of 3,523 were PrEP_NEW females (101% of the annual target), and a total of 1,789 PrEP_NEW males (972% of the annual target) were reached. During the reporting period, FSW showed high acceptability of PrEP (51%), followed by MSM (26%), and PWID (11%). However, in FY20, the PrEP_NEW annual target has only been met by 8% due to a shortage of Truvada for PrEP clients in the country. The USG technical team is working with MOCDECH to ensure the program is well positioned to strengthen supply chain coordination, demand creation and monitoring in order to achieve the substantial increase in targets proposed in COP20 (180,000 PrEP_NEW).

In FY20, the GoT amended the national HIV testing law to allow people to test themselves for HIV. Under the new law, GoT has committed to scale up HIVST nationwide focusing on KP and sexual partners of FSW who are reluctant to go for services because of stigma and other reasons. In FY19, a total of 37,908 clients were provided with HIV self-testing kits. In COP19, PEPFAR/T, in collaboration with GoT and IPs, are comprehensively scaling up HIV self-testing in three regions, while in COP20 HIVST will be scaled-up countrywide including promotion of and linkage to HIVST through peers, community workers, and health facility staff.

PEPFAR has committed to ensure HIV services among KP do not put people at risk. PEPFAR/T acknowledges the need to take extra precautions with the information collected, documented, or stored in electronic systems. PEPFAR/T and GoT have developed national KP M&E tools and a database for reporting all KP services with unique identifiers and data protection with the aim of protecting vulnerable people.

PEPFAR/T will continue using differentiated service delivery models for HIV case finding and linkages to treatment among KP/PP, which include self-testing, index testing, contact tracing, social/sexual network demand creation and testing, enhanced KP peer navigation/escorted referrals, and community ART initiation and refills for KP living with HIV. PEPFAR/T will continue supporting comprehensive service delivery that includes HTS, condom provision and promotion, ART, PMTCT, HIVST, and targeted community prevention interventions, including those that address gender norms and GBV. Additionally, PEPFAR/T, in collaboration with IPs, will continue identifying local CSOs that will work with KP, especially PWID, FSW and MSM, in order to accelerate geographic expansion of services. The CSOs will be routinely involved in designing, implementing and assessing the progress of KP services in Tanzania. Through this approach, peers/seeds have been selected as key contacts to enable increased access for PWID, FSW and MSM, to services such as HTS and to link those found to be HIV-positive to ART services.

It is the policy of GoT not to discriminate against people seeking health services based on sexual orientation or other factors. In COP19, the MoHCDGEC underscored the importance of training facility HCWs and law enforcement officials on stigma and discrimination and comprehensive services among KPs. PEPFAR/T will continue to encourage partners to utilize safety and security toolkits for KP. PEPFAR/T will continue advising the GoT on KP policy to ensure safe and appropriate access to services that adhere to international standards. Also, PEPFAR/T, in collaboration with GoT and CSOs, have established a national KP Advisory Committee composed of KPs who will work closely with the GoT to ensure the health needs of KPs are met across the whole portfolio of HIV prevention, care and treatment activities. In COP20, PEPFAR will continue to fund the implementation of stigma and discrimination sensitization programming for healthcare workers and law enforcement. In COP20, PEPFAR/T will continue engaging KP groups in the design and implementation of KP programs. Furthermore, in COP20, PEPFAR will scale-up the reach of the “U=U” (undetectable=untransmittable) message among KP.

Lastly, in FY19, PEPFAR/T provided medication assisted therapy (MAT) services to 4465 PWID. This is 73% of the annual target (6097). Among those reached, 4175 (93.5%) were male and 290 (6.5%) were female. In the reporting period, Henry Jackson Foundation overachieved due to low target setting. However, in FY19, African Medical and Research Foundation (AMREF) reported only KP_MAT results for Zanzibar and did not include Tanga, which resulted in its underperformance of 15.7% of the annual targets. AMREF, in collaboration with CDC, will soon establish MAT services in Tanga. Moreover, MDH has opened two MAT clinics in Bagamoyo and Kibaha in order to increase MAT services among PWID.

d. VMMC

In Tanzania, the VMMC program is a priority in councils with low male circumcision coverage and high HIV prevalence, including DREAMS districts. The program will continue to be a priority for HIV prevention as highlighted in the Tanzania National Country Operational Plan for VMMC (2014-2017), Health Sector HIV/AIDS Plan 2017 -2022 and the proposed National Operational Manual for Sustainable VMMC 2020 -2024. The priority age band for VMMC was selected based on impact and coverage modeling data from Avenir Health, which considers the age-structure of the population and HIV incidence, among other factors. During COP20, the Decision-Makers' Program Planning Toolkit, Version 2 (DMPPT 2) will be utilized as a monitoring and planning tool to estimate the coverage estimates and target and impact projections for the VMMC program at the district-level with data disaggregated by five-year age bands.

In FY19, PEPFAR/T supported 778,084 circumcisions, which accounted for 104% of the annual target of 748,738. The total number of VMMC performed in COP19 is expected to be 805,053. Building on efforts from COP19 and the new PEPFAR VMMC guidance, the COP20 strategy is to maintain high coverage among 15-29-year-old men in councils where circumcision coverage already exceeds 80% and achieve 80% coverage in councils where circumcision coverage is lower. Scale-up of VMMC will continue in FY21 to reach and maintain saturation in all strategic councils (i.e., seven attained, 63 scale-up, and 16 sustained councils), targeting 524,000 boys and men aged 15-29.

According to the 2016-17 THIS, the national MC prevalence is nearly 80% among 15-29-year-olds. The PEPFAR/T program is on track to reach the target of 90% MC prevalence among the 10-29 age band by the end of 2020. However, as coverage increases, pockets of low coverage remain in the country. Program data continue to highlight the coverage gap in men older than 24 years and in highly mobile men and communities in which men's occupations are characterized by seasonality (e.g. men working in the agricultural and mining sectors and fisher folk). Low coverage for the older age band justifies the continuation of VMMC targeting adult men.

PEPFAR/T recognizes the challenges of reaching adult men as the program matures. Therefore, the use of data sources and GIS mapping is imperative to drive strategic planning of VMMC service delivery for scale-up in priority districts. PEPFAR/T will continue to focus on scaling up VMMC services among older males age 25-29 by addressing key barriers. These obstacles include economic constraints, emotional reservations, service delivery convenience, structural set-up of facilities, and traditional and cultural norms. Findings show older men prefer mobile vans, male service providers, and tents that provide privacy for stigma reduction. PEPFAR/T will use client-centered approaches to strengthen demand generation efforts in priority SNUs to target adult men ages 15+ with relevant information and support. These efforts will include: engaging women through DREAMS and PMTCT programs by providing tailored information about benefits of VMMC for women and their key role as mothers and partners; involvement of traditional circumcisers in demand generation to mobilize clients, especially adults for services; leveraging other HIV services to educate men on VMMC post-counseling, particularly in the context of index testing; PrEP and social network-based outreach; and distributing clearly written, attractive brochures and leaflets printed in Swahili, targeted to specific audiences, such as parents and partners. PEPFAR/T's client-centered approaches also include age-specific SMS messages and interactive voice response (IVR) systems such as helpline services, peer networking, promotion through satisfied clients and a focus on reaching female spouses and sexual partners.

PEPFAR/T will implement user-friendly VMMC services tailored to ensure privacy for adult men, allow for separation of older men from younger men, extend hours and moonlight services, and use of the VIP VMMC services model targeting older men ages 25-29 years with a menu of premium options from which VMMC clients are allowed to customize how they wish to consume VMMC services, including flexibility for clients to choose the gender of the circumcising surgeons. In addition, IPs will focus on seasonal preferences and organize special campaigns to reach older clients and scale-up provision of VMMC services during this time. Lastly, the program will focus on workplace interventions tailored to fishing communities, mining areas, prisons, and refugee camps to reach adult men for VMMC services.

To ensure local ownership and sustainability of the VMMC program by local stakeholders, in COP20, PEPFAR/T will focus on engaging local partners for service delivery as it transitions the

program to local indigenous organizations for planning, management, ownership, and sustainability. The GoT will work in collaboration with partners to finalize a sustainability roadmap as a guide to VMMC stakeholders that will emphasize local resource mobilization, human resource capacity building, and good governance for sustainable VMMC services. PEPFAR/T will support plans and efforts to ensure VMMC services are integrated in routine services offered at all health facilities and the GoT has endorsed the use of reusable VMMC kits. During COP20, most MCs will be covered using reusable kits. PEPFAR/T and the Global Fund will also advocate for the implementation of device-driven circumcision using Shang ring. PEPFAR/T will work towards enhancing community and multi-sectoral engagement to increase service acceptance among older males by addressing myths, misconceptions and continued health education on benefits of VMMC through various platforms including: government, religious and local leaders' advocacy meetings, radio messages, and widely disseminated information, education, and communication (IEC) materials.

In COP20, PEPFAR/T will strengthen data quality, increase coordination, and improve sustainability of the VMMC program. While there has been considerable progress toward MC saturation, the VMMC program continues to require technical support to strengthen data quality and set targets for VMMC in priority locations and populations using modelling tools and enhanced partnerships. Furthermore, in COP20, PEPFAR/T will be receiving ambition funding to address the VMMC coverage gap in men > 25 years and in high-risk and hard to reach underserved groups. CDC and DOD have been awarded additional funds to enhance and expand evidence-based and data-informed innovative strategies and approaches including aggressive expansion of back-to-back outreach campaigns, the integration of Shang ring device, workplace-focused campaigns, and mobile VMMC vans to improve service access and enhance community engagement in reaching more adult men.

PEPFAR/T will focus on strengthening the quality of VMMC services through (1) the introduction of the online VMMC training module for VMMC site managers, program coordinators and VMMC providers to refresh technical skills and empower site-level decision-making to increase yield and safety, (2) coordinated supportive supervision and mentorship, (3) ensuring the incorporation of continuous quality improvement (CQI) in VMMC program implementation by implementing partners working with RHMTs, CHMTs and facility level staff to secure facility-led QI processes with local managers and stakeholders, and (4) external quality assurance (EQA) programs for better safety including adverse event (AE) monitoring, prevention and management. During COP20, PEPFAR/T will work with GoT to incorporate the provision of a minimum single dose of tetanus-toxoid-containing vaccination at the time of circumcision.

PEPFAR/T supports the NACP to monitor implementation of its standardized VMMC minimum package that includes the following: HIV prevention counseling, STI screening, screening for HTS, HTS, infection prevention, linkages to care or PrEP services for VMMC clients, the timely identification and management of adverse events, and facility-led QI processes. In COP20, PEPFAR/T will also continue supporting integration of VMMC in its youth and adolescent basic minimum package for HIV prevention which includes RH counseling, condom promotion, STI management/referrals, ART services, and psychosocial services.

Lastly, PEPFAR/T will work in collaboration with GoT to include commodities and supplies in comprehensive council health plans (CCHPs) and have VMMC services as part of insurance packages accepted by the National Health Insurance Fund (NHIF) for longer term sustainability.

4.4 Additional country-specific priorities listed in the planning level letter

In COP19, the Tanzania MoHCDGEC and PEPFAR/T discussed and recommended policy changes that were agreed upon to positively impact the PEPFAR/T programs. Many of the adopted policy changes were successfully implemented during COP19, including:

HIV self-testing. The Tanzania Parliament approved the law on self-testing in November 2019. Self-testing is currently underway in the three regions of Mwanza, Kagera, and Njombe. Regulations of the Amended HIV Act are being developed, along with a strategic plan, to support nationwide, self-testing scale-up nationally. The GoT Medical Stores Department will manage the HIV self-tests storage and distribution to ensure quality and sustainability.

Use of Dolutegravir (DTG) based regimen. The use of Dolutegravir based regimen is now implemented in all facilities following the GoT circular that was released in February 2020. In terms of proportion of eligible clients receiving DTG based regimen, the phase I and II facilities are at 80%, and phase III facilities are at nearly 30%. MoHCDGEC released a circular that instructs facilities to proceed with TLD transition in the remaining facilities throughout the country. With support from The Global Fund, the GoT is committed to removing Nevirapine-based regimen from facilities. This monumental achievement of scaling up Dolutegravir-based regimen needs to be sustained in order to improve program outcomes in COP20. Supporting an effective commodities supply chain, including coordinated commodities reporting, forecasting and quantification, will be an important step in supporting the supply chain.

Single national data system. The GoT agreed to strengthen and use the National Data System under the custody of the Ministry. At the PEPFAR/GoT quarterly meeting in November 2019, the Honorable Minister directed PEPFAR and NACP to jointly access CTC3 client level data. A PEPFAR/GoT joint Continuous Quality Improvement workshop took place from late November to early December 2019. Outcomes of the workshop included refined indicators for key policies (multi-month dispensing, IPT, same-day initiation, DTG implementation). Currently, the NACP and PEPFAR have prepared a Data Use Agreement for direct access to CTC3 client level data to sustain CQI collaboration.

Same-day initiation. Same-day initiation (within seven days) was one of the COP19 policy changes that GoT quickly adopted. A circular to adjust the time frame was distributed in May 2019 to allow same-day initiation at 241 priority sites. These sites represent more than 95% of patients who benefit from same-day initiation of ARVs. Initiation of ART within seven days has increased from 95% in January 2019 to 98.1% by the end of September 2019 in all regions. PEPFAR and GoT will continue monitoring implementation of this policy to ensure quality and performance are maintained and scaled up to tier II and III sites. Emphasis will be placed on ensuring clients who are identified as HIV positive and initiated on ARVs are directly linked to treatment - across all age, sex, and risk groups.

IPT scale-up. The scale up of IPT to eligible patients has improved significantly. The proportion of clients currently on IPT/TPT and those who have completed treatment is now at 60%. INH stock outs remain a challenge. To address this challenge, GoT and PEPFAR will target all eligible PLHIV, including children to complete IPT/TPT by the end of COP20. Cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.

Targeted testing. Targeted testing has been implemented with fidelity in order to avoid over testing. The number of tests conducted has decreased while there has been a steady increase in index testing, resulting in an increased yield of positives. GoT and PEPFAR will maintain

targeted testing while ensuring consent procedures and confidentiality are protected and the assessment of IPV continues. All children under age 19 with an HIV-positive parent will be targeted for HIV testing.

Facility-led, community-initiated ART. The policy on facility-led, community ART initiation has been successfully implemented. PEPFAR/T will now closely monitor facilities to ensure quality and proper documentation.

Joint planning and execution of COP. There have been eight monthly MoHCDGEC/PEPFAR joint technical meetings to discuss country progress towards the mutually agreed upon minimum HIV policy requirements for COP19. The Chief Medical Officer (CMO) chaired the joint meetings. The first quarterly, senior level meeting took place on October 29, 2019.

Optimized pediatric ARV. Optimized pediatric ARV regimen for children ≥ 20 kg has started in Phase I, Phase II, and Phase III facilities as part of the transition to dolutegravir-based regimens. In February 2020, the GoT released a circular emphasizing this regimen. With support from The Global Fund, the GoT is committed to removing Nevirapine based regimen from facilities.

While most policy changes have been effectively implemented, four are still in progress:

Lay/non-health HIV testing and counseling personnel. The GoT is not in support of allowing lay/non-health personnel to conduct HIV testing and counseling. The GoT is examining availability and interests of existing unemployed HRH and will assess how to cover the gap for personnel who will be performing HIV testing and counselling. The GoT plans to advertise HIV testing and counseling positions and solicit unemployed health workers. PEPFAR will continue advocating for using lay counselors as self-testing agents. During COP20 discussion, PEPFAR/T also agreed to hire 5000 community workers to support important prevention and treatment-related demand creation activities.

Circular to prohibit forced anal examinations. The Minister of Health will not be revising the circular to prohibit forced anal examination as discussed during the COP19 planning meetings. The Minister of Health rather endorsed the CSO-led KVP Forum and recommended revisions to the GoT's KVP Technical Working Group (TWG). These revisions eliminate the need to form a second, multi-stakeholder advisory committee, as the TWG can serve this function. MoHCDGEC also supports sensitizing law enforcement and health care workers on forced anal exams by way of including content on sensitization into their training curricula.

Six-month multi-month dispensing of ARVs. The GoT adopted and implemented differentiated service delivery models, including six-month multi-month dispensing (6MMD) and three-month dispensing. Early last year, GoT and PEPFAR started implementing six-month multi-month dispensing of ARVs. However, in July 2019, the GoT decided to withhold six-month multi-month dispensing due to ARV stockout concerns. The MoHCDGEC has approved to immediately start 6MMD in the Dar es Salaam region as of February 2020. Scale-up to all other regions are planned for COP20, with special attention dedicated to proper forecasting and quantification of ARVs to avoid stockouts.

PrEP. PrEP was initiated in Tanzania in the context of a research protocol. Based on COP19 discussions with the GoT, preparations have been underway to scale-up PrEP nationally. Nationwide scale-up efforts have been hampered due to Truvada shortages. At the end of 2019, the GoT agreed to the integration of PrEP as a comprehensive HIV service for KVP, including AGYW. M&E tools have been developed to monitor activities. The government is

currently creating mechanisms and processes to store and distribute PrEP commodities from the Medical Stores Department (MSD) and working with PEPFAR/T to reinstate training and demand creation activities. PrEP scale-up activities are intentionally being aligned with the development of KVP M&E tools to ensure monitoring of all activities.

Use of biometric finger scanning for unique identification. For the GoT, biometric finger scanning is one of multiple identifiers. HIV system software and documentation have been updated. Unique identification strategy is included in new HTS paper tools used at all sites. The National health client register development is ongoing for both deterministic and probabilistic matching. PEPFAR/T is supporting the implementation of the unique identification strategy in Afya Care and GotHOMIS. The NACP/MOH have submitted documentation for an eGov ICT data system design and security audit required for implementation of health sector unique identification. Initial focus of implementation will be on tier one sites to deploy the unique identification within CTC services. Preliminary use of CountTest data capture for HTS services indicates the volume of data entry is a burden on health facilities. PEPFAR and GoT will work to identify a range of approaches in addition to retrospective data entry, including integration of unique identification into all existing facility registration processes and other innovative approaches to data capture to improve unique identification registration for HTS services.

For COP20, there are several activities which are already being prioritized to positively impact the PEPFAR/T program. The activities include scale-up and rapid expansion of initiatives from COP19, as well as implementation of new, innovative approaches to achieve epidemic control.

PEPFAR/T has consistently prioritized retention, and previous and current efforts have translated into steady improvements in retention above the results of the THIS. However, as PEPFAR/T moves towards the goal of reaching 95-95-95, retention efforts need to be further improved. In May 2019, a GoT circular was issued supporting the roll out of community-based ART initiation and one-month refills. This is already being implemented, and further expansion across the country will improve both linkage and retention, especially among KP and other hard-to-reach populations.

In February 2020, GoT formally endorsed implementation of six-month dispensing for ART. The first clients received six-month dispensing in Dar es Salaam with PEPFAR/T support for supply chain and storage systems, provider education, and patient treatment literacy.

The pediatric cascade (including case finding and service delivery) will continue to be a priority for PEPFAR/T in COP20. From a case finding standpoint, early infant diagnosis programs have already shown great improvement from COP18 to COP19 through focusing on connecting mother-baby pairs using GoT registers and electronic health systems. We plan to ensure that these systems are fully implemented during COP20 to achieve the goal of full EID coverage for all HIV-exposed infants.

In addition, pediatric case finding efforts are also impacted by index testing services for biological children of WLHIV. During COP20, PEPFAR/T plans to continue emphasizing that all WLHIV be routinely offered index testing services and that all eligible children be offered testing. Pediatric care will also be a priority as the program continues to transition away from Nevirapine based regimens for pediatric HIV clients, and transition to LPV/r or DTG based regimens, depending on age and weight. We believe that this transition will be crucial to addressing the larger issue of poor viral suppression among children and adolescents.

Details on the PEPFAR/T partner management strategy for optimizing partner performance are included in section 4.5.

For ensuring alignment with the PEPFAR strategy, PEPFAR/T uses several approaches:

- 1) Partners are included in the annual COP strategy meetings and have the opportunity to discuss the COP guidance and provide feedback on implementation strategy. During this meeting, they have the chance to engage with PEPFAR/T staff, S/GAC, the Government of Tanzania, civil society and other donors.
- 2) Partner work plans are submitted annually and updated as needed when strategies change. This ensures that written work plans that partners have agreed to implement are aligned with the most recent strategy decisions.
- 3) PEPFAR/T holds weekly inter-agency PEPFAR Steering Committee meetings. These are internal to USG and are utilized to review data and rapidly share best practices or challenges being faced. When a best practice is identified, PEPFAR/T works to scale that up across partners.
- 4) At the end of COP17 PEPFAR/T established a monthly data portal to review the progress of facility and community partners on a key sub-set of indicators more frequently. Monthly data review and discussions with partners allows for more immediate course corrections and site visit planning. To support PEPFAR/T's focus in COP20, the monthly data portal will also include pediatric indicators so staff and partners can track progress on identification and viral load suppression.
- 5) PEPFAR/T holds full partner management meetings quarterly, but also meets monthly with clinical implementing partners. This allows for collaborative performance reviews and discussion of programmatic shifts that are required.
- 6) PEPFAR/T holds all-partner meetings at least quarterly. At these meetings, the team announces any changes that affect multiple partners to allow for immediate implementation, and low performing partners will be placed on performance improvement plans.
- 7) PEPFAR/T engages with GoT regularly. Starting in early 2018, the team began holding monthly meetings with GoT to discuss progress and to determine any shifts needed. At the Johannesburg Regional Planning meeting in 2019, the GoT and USG agreed to enhance this. Monthly meetings at the technical level will be held to review data and to discuss any actions that are needed. Quarterly meetings will occur at the senior level to review progress and to ensure accountability. This will help to ensure that if GoT action is required or would be helpful to address challenges or to enhance performance, it can be done rapidly. Most recently, PEPFAR/T and the GoT agreed to monthly meetings to supply chain plans and issues related to laboratory services, which are crucial to program implementation.

Many of the evidence-based solutions that will be brought to scale in COP19 are described in section 4.3.1. Additional evidence-based solutions that will be brought to scale that do not involve policy change include:

1. *Rapid scale-up of index testing.* 2019 saw a tremendous increase in index testing across the country. PEPFAR/T plans to continue to sustain these efforts, while emphasizing a client-centered approach.
2. *TB preventive therapy scale-up will continue.* A main barrier previously was lack of adequate supply, but this is now resolved.
3. *Male identification strategies that have succeeded, including community-based testing for miners, clients of sex workers, fisherfolk, and other KVP.* The index testing modality has also increased identification of men with HIV. Furthermore, site level data have shown that community-based male peer leaders supported by PEPFAR/T's social behavior change activity has contributed to an increase in male case finding at the facility. These activities will continue to be scaled up.
4. *To improve retention, community tracking within four days of a missed appointment will be done.* Innovative strategies already in place include the three-box approach, whereby a box exists for charts of people who are scheduled to come to clinic the next day, that day, or who have missed an appointment. There are several variants of this strategy, but the principle is being scaled-up nationally.

PEPFAR/T is committed to ensuring that all index testing services are client centered. PEPFAR/T has demonstrated its ability to successfully scale-up index testing, and the focus now is on quality. PEPFAR/T will draw on the core tenets of high-quality services, with an overall goal of ensuring that services are non-coercive, private, and confidential. PEPFAR/T will not be using targets to drive performance, but rather emphasize the importance of index testing to identify undiagnosed contacts. PEPFAR/T will continue to engage KP, including peer counselors, as a best practice, and will also continue to ensure that interested clients select their preferred notification method. Finally, PEPFAR/T is looking forward to collaborating with CSOs and communities to adopt a monitoring approach that makes sense and serves the best interests of all clients. Community-based testing will focus on index contact testing and KVP s testing. Both strategies have seen substantial success, with quarter-on-quarter increases in HIV positive identification and increases in identification of men with HIV.

Facility-based testing will always occur with pre-screening for symptoms and HIV risk. A national screening tool has been developed and approved and is now being implemented. The BCPE linkage case management model approach will be implemented at all these facilities, which has a demonstrated impact on increasing yield, and, at times, also increases the number of positives identified when facilities had low testing coverage. GoT is de-emphasizing mass tasting campaigns in favor of targeted testing using high-yield modalities.

The above strategies focus PEPFAR/T's testing investments on proven modalities well-matched to Tanzania's current gaps in identification and ART coverage. The strategies also increase the yield of each approach, even in non-PEPFAR/T supported testing settings.

4.5 Commodities

The availability and accessibility of life-saving health commodities is a cornerstone of epidemic control and achieving the 95-95-95 goals. The demand for commodities has risen as programs have expanded to more patients and advanced toward epidemic control. This has increased both the financial need for commodity procurement and the management burden of large volumes of commodities. Global shortages of key commodities introduce a challenge in Tanzania's ability to secure the total volumes needed. For example, key pediatric ARVs such as Lopinavir/Ritonavir 100/25 mg tablets faced national stock outs in Tanzania in 2019;

manufacturers and procurement agents were unable to respond quickly with the stock needed. In-country stakeholders identified quantities of drugs needed to meet the anticipated demand for this drug in 2020 and planned for a nine-month lead time for drug delivery. In February 2020, continued global drug shortages for this product now have extended the lead time for receipt of full supply to up to 13 months after the order date. Other products, such as Isoniazid and Emtricitabine/Tenofovir DF 200/300 mg tablets, have or may face a rise in demand that outstrips manufacturers ability to ensure full supply. Tanzania is particularly vulnerable to these global impacts due to the size of Tanzania’s program and its central role in driving global demand.

Activities in Tanzania will focus on improving forecast accuracy in quantification and improving the alignment of demand estimates with program scale up. Monthly meetings with PEPFAR/T and the supply chain staff at the NACP have been instituted in COP19 to support this important activity. During the TLD transition, the program forecasted needs and created a distribution plan for pre-positioning stock in anticipation for increased demand at the facility level. Similar activities for the introduction of pediatric granules are ongoing; plans for the distribution for TE for the PrEP program are underway.

As product types and volumes increase, so too does the complexity of the in-country supply chain. Long term investments in the Medical Stores Department, the Logistics Management Unit, and other supportive supply chain institutions have allowed Tanzania’s public health supply chain system to support increased demands. Recommendations from a holistic supply chain review are being implemented in order to improve functionality and planning. The supply chain system redesign has been implemented in Mwanza and is currently being rolled out across the country. This design moves the supply chain system from a quarterly to a monthly reporting system, allowing for more current facility-level data. The new, more efficient supply chain design makes the system more responsive to changes in consumption and provides increased visibility of stock availability at the service delivery level. Bottom-up quantification focuses on facilities identifying their own commodity needs. Improved access to and utilization of facility-level data ensures a more client-centered approach as it puts the needs of health facilities—where the patients are—at the forefront of national decision making.

Table 2.3.2 Annual Procurement Profile for Key Commodities

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	\$160,000,000	40	60	-	-
Rapid test kits	16,000,000	-	100	-	-
Other drugs	4,000,000	3	-	97	-
Lab reagents	\$77,000,000	50	-	50	-
Condoms	\$10,000,000	7	51	20	22
VMMC kits	5,200,000	100	-	-	-
Other commodities	\$8,800,000	1	70	29	-
Total	\$280,000,000	-	-	-	-

4.6 Collaboration, Integration and Monitoring

4.6.1 Strengthening cross-technical collaborations and implementation across agencies and with external stakeholders, including the GFATM and MOH

The PEPFAR program in Tanzania is coordinated and managed through the interagency team consisting of PEPFAR Coordination Office, USAID, CDC, and DOD with each agency ensuring

teamwork, results sharing, data-informed decision making, and strategic staffing. The guiding principles include interagency collaboration, data transparency, efficient programming and sustainability, and ownership. Technical teams within and across the agencies operate through specific Technical Working Groups to foster constructive dialogues between agencies to stimulate innovation and enhance program standardization. At the management level, the PEPFAR Steering Committee provides regular opportunities to inform each agency about activities and initiatives which optimizes efficiency across PEPFAR/T programs.

There continues to be regular engagement between PEPFAR/T and GOT. PEPFAR/T personnel are members of national technical working groups that convene regularly to address program implementation and propose policy adaptations. What started in FY18 as PEPFAR/T leadership monthly meetings with the Deputy Minister for Health and other senior MOH teams to track policy and performance, has transitioned to monthly meetings with GOT technical staff to monitor implementation progress of the COP19 agreed upon minimum policy commitments. On a quarterly basis, these meetings are chaired by the Minister for Health. PEPFAR/T is also engaging in monthly coordination meetings with UNAIDS, WHO, GFATM, UNICEF, and other UN organizations to ensure that shifts in priorities are shared and program barriers are urgently identified and addressed in a unified and collaborative manner.

PEPFAR/T, the GFATM and the GOT work together to support the national HIV commodities supply plan. With respect to the implementation of community services, including those targeting KVPs, PEPFAR/T works closely with GFATM principal recipients (PRs) to geographically align partners and programs to prevent double funding.

4.6.2 Strengthening Partner Management

In COP20 PEPFAR/T will build off important practices around partner management that were developed in COP18 and COP19. PEPFAR/T will continue to strengthen approaches and processes to ensure highly effective, timely, and standardized partner management is in place to achieve COP20 targets and to improve identified gaps. This process is data-driven and managed in two steps: 1) implementation and reporting, and 2) using data to improve performance. In FY20, PEPFAR/T is conducting all these steps as an interagency, to ensure optimal sharing of best practices, challenges, and remediation steps across all partners. Practices that were implemented and scaled-up during COP18 and COP19 will continue across all partners, nationally.

- 1) **Implementation & Reporting:** In COP20, PEPFAR/T will continue to use a comprehensive set of information to assess partner performance, paired with several key approaches to improving that performance. The assessment of partner performance starts with standard PEPFAR metrics - using the PEPFAR Monitoring, Evaluation, and Reporting (MER); Site Improvement Monitoring System (SIMS); and financials by reviewing outlays and budget analysis - all of which are currently available on a quarterly basis. Additionally, starting immediately after COP18 planning was completed, PEPFAR/T implemented routine monthly reporting from all facilities covering 80% of TX_CURR on key strategies that were being implemented. We have used this data during the latter half of COP17 implementation and throughout COP18 and COP19 to rapidly accelerate progress in these key priority areas. The data collected include index testing indicators, data on optimized PITC, data on policies reaching patients (proportion of patients receiving same-day initiation, multi-month scripting, and IPT), linkage, retention, and viral load data. In COP19 and 20 data will continue be collected in order to monitor progress on the pediatric cascade, and to address poor performance in this

area. We further enhanced this approach by adding a more intensive review of selected data from under-performing facilities among the 241 facilities that comprise 50% of the TX_CURR in the country. This has been further enhanced by the GOT's commitment to activate the EOC for more focused, joint monitoring of activities at the 241 priority sites to ensure policy changes are reaching PEPFAR patients, and by the introduction of PIPs for partners that consistently fail to meet targets. PEPFAR/T is committed to transitioning to the use of one data system with the MOH. As the GOT clinical care database reaches full implementation, most of these indicators will transition to being extracted directly from that system. Quality management and integrated analysis will be applied to identify facility and community sites that are under-performing, improve implementation fidelity and support the achievement of outcomes to drive epidemic control. PEPFAR/T will use real-time, robust analysis of data to refine continuous quality improvement plans and identify successful facilitating factors that could be scaled up.

2) **Use of granular data to improve performance:**

- a. **Regional Teams in COP20:** Immediately after the COP19 approval meeting in DC, USG "regional teams" were launched, whereby regions were divided amongst teams of USG staff, who were responsible for supporting those regions, with a focus on the facilities accounting for 80% of TX_CURR in those regions. These teams conducted multiple site visits to the regions and supported IPs in accelerating progress. The teams were also responsible for SIMS visits occurring within their regions, thus providing greater continuity in their relationship with the regional and district partner and GOT staff. The GOT assigned three of its staff from the national level to join these teams and participate in site visits. Data were used to identify specific gaps both in region-level performance as well as facility-level performance, and technical assistance was provided to address identified gaps. In selected regions with especially large gaps in identification, this approach was enhanced with a long-term USG presence. Two staff were deployed to Mwanza for one month in November 2018, and three staff were deployed each to Mwanza and Kagera for three months as of February 2019.
- b. **Continuing the Regional Teams:** The regional team approach has been successful and was expanded during COP19. Currently, all regions in Tanzania have a USG staff-team assigned to them. Partners have also assigned a staff lead for each facility. Granular data from each facility is reviewed regularly to measure progress against key goals. For example, for index testing, we measure the number of sexual partners enumerated per index case, the proportion of those who are tested, and the testing yield. These data, which identify specific, modifiable gaps, have been critical in achieving gains seen in some regions and will be critical for continuing rapid scale-up.
- c. **Additional focus for under-performing sites:** High-volume and low performing sites will continue to be prioritized for SIMS visits, which will include tracking of remediation across all performance measures (program achievements, quality, and expenditure). Likewise, among the 241 sites, regular site visits will occur for those that are falling short of specific targets. When partner performance is of concern, PEPFAR/T management teams will increase the frequency of the reviews to weekly remediation actions and utilize benchmarks to monitor progress on a specified timeline.
- d. **Addressing financial performance:** Over-spending will neither be approved nor accepted. If spending is outpacing target achievement or monthly burn rate toward the approved annual budget, a financial remediation plan will be enacted.

- e. **Addressing overall partner deficiencies:** Formal Partner Performance Improvement Plans will be implemented in cases of prolonged underperformance. There may be situations, either epidemiological or related to partner performance that require shifting funds from one partner to another. In this case, PEPFAR/T will submit reprogramming requests to ensure these adjustments are made in a timely manner.
- 3) **Ensuring excellent overall performance:** On a monthly and quarterly basis agency and interagency teams will continue to assess the progress being made in 2020 to achieve targets overall and across sub-populations. The assessments will include analysis of performance against targets and investigate whether priority interventions are achieving expected results. The PEPFAR/T interagency team, along with the GOT, will continue to discuss how barriers can be addressed and how opportunities should be capitalized on collectively, both for site-level and for above-site activities. This information will be presented quarterly in the POART. Immediately following the POART, PEPFAR/T will continue to meet with GOT, CSOs, and IPs to discuss findings from the previous quarter and agree on appropriate remedial measures. Agency and Embassy Leadership will also meet monthly with the MoHCDGEC leadership to review monthly data, policy implementation and address programmatic gaps.

To continue to foster a grassroots network of indigenous organizations and drive more local investment, PEPFAR/T will also engage with CSOs – both those receiving PEPFAR funding through sub-awards and those not receiving PEPFAR funds. This will include quarterly meetings and implementation of a Tanzania-specific CSO representative group as well as those engaged in community-led monitoring. The strategy clearly outlines PEPFAR T’s CSO-engagement approach and includes proposed indicators to measure the extent to which more established IPs engage with and build the capacity of grassroots, indigenous organizations with the goal of helping position CSOs to take increasingly larger roles in the implementation of PEPFAR/T programming. PEPFAR/T will continue to prioritize engagement with PLHIV and KP communities and organizations to build on their experience carrying out peer support, outreach, awareness-raising, and treatment literacy to ensure program success. This will, in part, be achieved through the KP Forum that was established in COP19.

4.6.3 Improving Integration of Health Systems Interventions

In COP20, PEPFAR/T will continue to collaborate and coordinate with GOT to address key HRH gaps that stand as key barriers to fully implementing activities required for epidemic control. The investment and technical assistance to HRH have been targeted to improve the allocation and performance of service HCWs using both community and clinical site-specific service delivery data to identify need and alignment PEPFAR HCWs support with GOT human resources processes for sustainability. Evidence-based approaches will be used to estimate the site level needs for HCWs and the distribution thereafter. Client-centered approaches and performance management will be implemented in COP20.

For Laboratory services, PEPFAR/T will maintain certification and accreditation standards of 19 laboratories to meet the required operational standards while continuing to mentor 41 laboratories towards ISO15189 accreditation. The program will continue to expand the HIV proficiency testing program to 100% HIV testing sites for continuously improved quality of HIV testing services. In addition, the program will support training and certification of testers at all high volume PEPFAR/T supported sites.

PEPFAR/T will continue to support viral load (VL) testing coverage to ensure that all eligible patients receive at least one VL test. In collaboration with health care providers and implementing partners, PEPFAR/T will scale-up VL demand creation activities; improve the sample tracking electronic system using QR codes; and reduce lab result turnaround time through remote login laboratory requests and use of the POC-based early infant diagnosis (EID) for VL testing in hard to reach facilities mapped in collaboration with GOT. To ensure utilization of viral load results by health care providers, PEPFAR/T will continue to support the national laboratory information system by linking viral load laboratory data to the CTC3 database for the timely return of viral load test results and improve patient management along the continuum of health care delivery. In addition, PEPFAR/T in collaboration with GOT will support Diagnostic Network Optimization strategies to review spoke-hub-lab referral plan, equipment placement and laboratory supply chain system, strengthen the sample referral system by integrating VL, EID, TB, outbreak and surveillance utilizing the same hub and spoke the sample transport model. PEPFAR/T will also support the scale-up of LAM Assay for TB screening of HIV clients with advanced HIV disease and will continue to use data and explore opportunities for Multiplexing and diagnostic integration for POC HIV and TB testing within the existing diagnostic network.

4.6.4 Improving Quality and Efficiency of Service Delivery

PEPFAR/T is focused on key principles that are foundational for program success and have been essential to the accelerated progress toward epidemic control that Tanzania has demonstrated over the past year. These key principles – utilizing people, data and systems to drive impact – are at the heart of the PEPFAR/T approach to improving the quality and efficiency of service delivery. Using a continuous quality improvement (CQI) approach, supported by the focused use of data down to the site level, the introduction of new tools, and monitoring at national, health facility and implementing partner levels, in close collaboration with Government of Tanzania, PEPFAR/T has been able to use the regular and detailed information necessary to make quick, incremental improvements in scale-up of key interventions and implementation of strategies to support improved models of care delivery across community and facility sites. PEPFAR/T has also supported the expansion of innovative platforms such as Project ECHO Tanzania to catalyze sharing of knowledge, dissemination of best practices and creation of communities of practice that link together the expertise and lived experience across geography and time to enhance peer learning, provider capacity and translation of policy into practice.

In COP20, PEPFAR/T and GOT will continue working closely together to sustain the gains, build on successes by expanding the reach of proven strategies, and focus on client and family-centered approaches that measure progress not just by the number of people reached but also by the quality of the services delivered and the strength of the systems to put people at the center.

4.6.5 Supporting community-led monitoring of treatment services with minimum quarterly meetings to review reported observations and recommendations with representatives and follow up as needed

PEPFAR/T has been actively engaging with CSOs, UNAIDS, and GOT counterparts to prepare for the design and implementation of community-led monitoring in COP20. CSOs have developed a framework for community-led monitoring and have begun to identify priority

indicators- including specific indicators for KVP services and stigma and discrimination - to measure. Recognizing that funding is insufficient to roll out a national program, PEPFAR/T conducted an analysis to identify geographic areas of focus for these activities. Approximately 20 districts were prioritized based on low retention rates, followed by low viral load suppression rates. These areas will be the first to receive community-led monitoring activities, with possible scale-up planned based on lessons learned from these specific areas.

Community-led monitoring activities will be supported primarily by the PEPFAR Small Grants program, as well as through USAID's ongoing activities with the National Council for People Living with HIV/AIDS (NACOPHA). A CDC M&E partner will likely offer technical assistance for NACOPHA and selected CSOs to finalize the data collection tools, and in data collection itself. As per the requirements of the Small Grants program, formal reports will be generated quarterly and disseminated among local health teams and PEPFAR who will facilitate discussion of the findings with implementing partners and higher levels of government to ensure continuous quality improvement at the facility level. The PEPFAR Coordination Office will release a Notice of Funding Opportunity allowing community-based organizations to competitively bid to operationalize community led monitoring in their respective locations.

4.6.6 Ensuring above service delivery activities are mapped to key barriers and measurable outcomes related to reaching epidemic control

Above-site and non-service delivery activities at the site level are the foundation of the PEPFAR/T program to strengthen the GOTs ability and long-term capacity to manage HIV response and ensure the sustainability of investments made. Critical above-site programmatic elements include data systems and real-time data utilization, HIV-related surveys and surveillance systems, supply chain, human resources for health (HRH) and competency-based skills building and knowledge sharing to support high-quality HIV service delivery, laboratory, governance and information systems. Advancing domestic resource mobilization and the total market approach will also ensure the utilization of GOT resources for greater shared responsibility to sustain epidemic control. In this regard, PEPFAR/T COP19 activities have integrated and aligned key functions of the HIV program for institutionalization into existing government systems.

In COP20, PEPFAR/T will continue to collaborate with other stakeholders to support identification, monitoring and evaluation of above-site investments to make a strategic pivoted shift in accordance with PEPFAR priorities to ensure the country is moving toward reaching epidemic control. Above-site level activities are mapped to key barriers through measurable indicators and linked to site level (service & non-service delivery) activities, and deliverables. This is reviewed using documented outcomes from the implementation of COP19, Table 6, Sustainability Index and Dashboard (SID) results, MER, SIMS and other contextual information. In addition, guidance from the Planning Level Letter (PLL) that highlighted the key programmatic challenges, partner performance issues, Minimum Program Requirements (categorized by Care & treatment, Case Finding, Prevention & OVC and Policy & Public Health Systems Support), were considered as part of the above site activities for COP20. This will ensure implementation in addressing the challenges faced, where some are policy-related, and others are capacity related. PEPFAR/T will continue to address the sustainability barriers identified in the most recent SID that was completed in 2019, including service delivery efficiency and quality of service, gaps in domestic resource mobilization (GOT commitment to finance at least 30% of national HIV response), full integration of quality improvement concepts and laboratory capacity, which will help make services more accessible and efficient to clients. The GOT and various stakeholders will review the same disaggregated cascade analyses and agree on joint solutions to reach the UNAIDS Fast-Track Goals while realizing additional budget efficiencies.

PEPFAR/T historically uses a monitoring and evaluation tool/matrix known as Table 6 that identifies key barriers, above-site program areas, activities and links them to specific indicators and benchmarks (short, intermediate and long term). PEPFAR/T will make assessments for continued investments at the site and above-site, based on data from the current national level of ARV coverage, across age, sex and risk groups, as described in various sections of the document.

In addition, PEPFAR/T and the GOT are prioritizing health system interventions to better track clients across services, across sites and over time. This will ensure that people receive the services needed to stay healthy, and it will also facilitate the accurate measurement of retention. PEPFAR/T and the GOT are working together to implement and take to scale a comprehensive unique identification strategy. The strategy includes a National Health Identification Standard (NHIS) and a new HTS register with improved identification fields aligned with NHIS. PEPFAR/T is working on a multi-faceted NHIS that includes biometrics as one of the multiple identifiers and a national health client register for both deterministic and probabilistic matching. Tanzania has implemented system updates in HIV system software to deploy the unique identification strategy in HIV systems once a GOT ICT system audit has been completed. Client register development is underway. In addition, the strategy includes an immediate scale-up of biometrics in HIV C&T sites covering 80% of TX_CURR, and a National Health Client Register to support probabilistic matching of clients. Community-led monitoring may be an opportunity to ensure confidentiality is maintained and to minimize risks of loss of privacy in this context.

Finally, PEPFAR/T will continue to work collaboratively with MoHCDGEC and PO-RALG through the existing GOT platforms to ensure COP20 implementation reflects all relevant policies and guidelines regarding HIV/AIDS programming. Specific policy developments that support implementation include community outreach ART, completion of transition to TLD, differentiated service delivery including 6-month MMD, nurse-initiated management of ART, HIV case-based surveillance (CBS), enabling lay workers to perform HIV testing, TPT for all PLHIV, completion of VL/EID optimization and deployment for community health workers for a task-sharing policy. In addition, PEPFAR/T will continue to support GOT to adopt newer pediatric formulations of ARVs to improve clinical outcomes, scale-up of index and HIV self-testing and include HIV recency surveillance as part of routine program activities. This is part of the Government to Government (G2G) engagement to ensure proper coordination and implementation of key HIV policies with fidelity.

4.6.7 Use of Unique Identification across sites and programs in clinical settings

PEPFAR/T and the GOT have been working in collaboration to develop a comprehensive strategy and implement systems to address unique identification across sites, services and programs in clinical settings. The identification strategy and systems design are aligned with the National e-health strategy and Digital Investment road map and WHO guidance. This comprehensive health sector approach helps avoid the possibility of stigma and discrimination as it becomes a commonly accepted practice for all health services and person-centered care.

Client identification in the health sector will leverage multiple identification options that are available and acceptable for each individual as they present for health services. In FY19 Tanzania defined a National Health Client Identification Standard (NHCIS) that defines this common approach and set of identifiers like common government IDs, date of birth, biometrics, etc. In FY20 GOT and PEPFAR/T supported partners are developing the National Health Client Register (NHCR) that will serve as a master source for determining identity and de-duplicating client information using deterministic and probabilistic matching. Concurrently, the sector is

working to update paper and electronic registration systems at the facility level to capture identifying information in accordance with the NHCIS.

Within HIV, the HTS register, and the CTC suite of software have already been updated to incorporate standard identifiers including biometrics matching. National software has been updated to support deterministic matching including biometric matching. Within FY20, PEPFAR/T expect to complete eGov ICT Security audit and regional IPs will support the scale of new software and registration processes in high volume, Tier 1 within the current financial year.

There are other important considerations influencing planning for unique identification. It is vital that all beneficiaries fully understand protections established to protect their data, and health facility responsibilities regarding confidentiality. NGO forums, civil society groups, and PLHIV representatives will be engaged to support education and communication with all stakeholders. Similarly, it is vital that no client is ever turned away from HIV services because they do not want to provide prescribed identification information. The GOT NACP, PEPFAR/T, and other stakeholders have designed a new M& E and client records approach for prevention services including key and vulnerable population (KVP) and priority population (PP) services. This new approach separates KVP and PP type from identifying information to support some limited type disaggregation while ensuring client identification can be used to provide longitudinal prevention services without KVP and PP type information.

4.7 Targets for Scale Up Location and Populations

Standard Table 4.7.1: Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts

Entry Streams for ART Enrollment	Tested for HIV (APR FY21) HTS_TST	Newly Identified Positive (APR FY21) HTS_TST_POS	Newly Initiated on ART (APR FY21) TX_NEW
Total Men	918,036	67,158	63,863
Total Women	1,232,514	95,884	91,012
Total Children (<15)	212,447	7,895	8,315
Total from Index Testing	434,318	92,806	87,789
Adults			
TB Patients	24,967	4,031	3,931
Pregnant Women	529,437	9,424	8,915
VMMC clients	NA	NA	NA
Key populations	72,570	7,257	NA
Priority Populations	184,304	3,502	NA
Other Testing	778,648	43,819	53,718
Previously diagnosed and/or in care	NA	NA	NA
Pediatrics (<15)			
HIV Exposed Infants	37,684	836	842
Other pediatric testing	55,283	489	4,280
Previously diagnosed and/or in care	NA	NA	NA

Standard Table 4.7.2: VMMC Coverage and Targets by Age Bracket in Scale-up Councils

SNU	Size estimate (10-29yrs)	Target - VMMC CIRC (15-29yrs, FY20)*	Current coverage (end of FY20) using National average	Target - VMMC CIRC (FY21); 15-29yrs	Expected Coverage (In FY21) using National average
Military Tanzania		9,163		2,738	100%
Arusha CC	86,117	0		-	
Arusha DC	58,328	0		-	
Biharamulo DC	56,684	2,380	78%	4,352	100%
Buchosa DC	55,565	5,997	79%	-	100%
Bukoba DC	47,256	5,174	78%	427	100%
Biome DC	41,783	1,777	78%	2,303	100%
Bunda DC	39,729	6,544	100%	2,765	100%
Busega DC	38,246	0		-	
Chalinze DC	34,165	0		-	
Chato DC	65,936	3,047	78%	3,867	100%
Gairo DC	30,422	2,478	78%	-	
Geita DC	113,018	10,154	78%	12,796	100%
Geita TC	40,948	4,062	78%	2,511	100%
Igunga DC	70,053	5,748	78%	14,468	100%
Ilala MC	174,773	0		-	
Ileje DC	20,655	3,723	78%	16,757	100%
Iramba DC	41,065	4,765	78%	3,775	100%
Iringa DC	41,327	2,076	100%	2,880	100%
Itilima DC	52,904	4,032	78%	31,185	100%
Kalambo DC	34,290	5,179	78%	25,604	100%
Kaliua DC	71,424	7,655	78%	16,919	100%
Karagwe DC	62,060	2,434	78%	1,842	100%
Kibaha TC	26,339	0		-	
Kigamboni MC	23,822	0		-	
Kigoma Ujiji MC	46,717	0		971	100%
Kilolo DC	36,264	2,776	78%	2,592	100%
Kilombero DC	49,966	16,197	78%	6,952	100%
Kilosa DC	72,202	9,912	100%	-	
Kinondoni MC	142,138	0		-	
Kishapu DC	47,935	0		-	
Kondoa DC	35,012	0		-	
Kondoa TC	11,096	0		-	
Kongwa DC	52,890	0		-	
Korogwe DC	40,424	0		-	
Kwimba DC	66,398	6,371	78%	4,865	100%
Kyela DC	37,136	3,860	78%	3,931	100%
Kyerwa DC	56,487	4,372	78%	5,806	100%

Ludewa DC	22,650	2,283	78%	2,223	100%
Lushoto DC	48,719	0		-	
Mafinga TC	17,012	0		989	100%
Magharibi B	31,841	0		-	
Magu DC	49,774	5,917	78%	4,866	100%
Makambako TC	18,624	2,167	78%	2,195	100%
Makete DC	16,722	1,369	78%	1,209	100%
Masasi DC	41,104	0		-	
Maswa DC	67,228	0		-	
Mbarali DC	48,354	8,105	78%	5,744	100%
Mbeya DC	50,180	0		1,188	100%
Mbinga DC	39,772	25,632	95%	219	100%
Mbinga TC	23,984	0		97	100%
Mbogwe DC	35,364	2,538	78%	4,534	100%
Mbozi DC	81,062	5,621	78%	24,656	100%
Meatu DC	55,657	3,806	78%	25,262	100%
Missenyi DC	36,730	3,456	78%	1,683	100%
Misungwi DC	58,464	5,543	78%	7,010	100%
Mjini	41,105	0		-	
Mkuranga DC	33,320	0		-	
Momba DC	24,502	3,050	100%	1,271	100%
Morogoro DC	42,742	9,966	100%	-	
Moshi DC	81,153	0	78%	-	
Mpanda DC	30,018	0	78%	264	100%
Mpanda MC	21,739	3,567	78%	2,451	100%
Msalala DC	42,168	10,310	78%	21,304	100%
Mufindi DC	41,275	2,857	78%	2,612	100%
Muheza DC	37,411	0		-	
Muleba DC	95,395	3,550	78%	2,806	100%
Musoma DC	37,931	6,544	78%	1,867	100%
Musoma MC	28,829	0		-	
Myomero DC	50,479	8,927	78%	3,751	100%
Namtumbo DC	31,794	6,604	78%	4,277	100%
Ngara DC	53,126	3,967	78%	6,716	100%
Njombe DC	14,774	3,114	78%	2,405	100%
Nkasi DC	47,551	7,156	78%	11,823	100%
Nzega DC	76,231	6,414	78%	9,801	100%
Rorya DC	43,754	0		-	
Rungwe DC	39,132	5,331	78%	10,993	100%
Sengerema DC	58,814	3,284	78%	6,893	100%
Serengeti DC	43,856	0		-	
Shinyanga DC	55,967	6,036	78%	4,019	100%
Shinyanga MC	34,129	3,698	78%	1,234	100%

Songea DC	21,678	7,822	100%	1,142	100%
Songwe DC	22,886	3,050	78%	2,298	100%
Sumbawanga DC	51,526	0		5,825	100%
Sumbawanga MC	43,597	7,256	78%	8,541	100%
Tanga CC	80,482	0		-	
Tarime TC	15,928	0		-	
Temeke MC	173,875	0		-	
Tunduma TC	25,877	5,410	78%	6,983	100%
Tunduru DC	46,370	8,481	78%	4,515	100%
Ubungo MC	125,659	0		-	
Ukerewe DC	57,291	1,920	78%	12,716	100%
Ulanga DC	25,580	12,015	100%	-	
Urambo DC	36,268	2,450	78%	7,674	100%
Ushetu DC	47,636	20,472	78%	12,303	100%
Uvinza DC	67,191	4,945	100%	17,389	100%
Uyui DC	68,639	7,962	78%	15,399	100%
Wanging'ombe DC	26,871	4,698	78%	1,898	100%
TOTAL	4,789,344	368,006		440,413	

*Guidance from S/GAC mandates, countries stop VMMC_CIRC services for beneficiaries under the age of 15; targets have been amended accordingly

Standard Table 4.7.3: Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY21)	FY21 Target
PP_PREV	368,876	AGYW (15-19) 25% AGYW (20-24) 45%	531,218
KP_PREV	191,033	KP (FSW 95%; MSM 85%; PWID 90%)	175,932
KP_MAT	9,974	90%	5,918
TOTAL	5,498,236		713,068

Standard Table 4.7.4: Targets for OVC and Linkages to HIV Services

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY20 Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY20 Target)
_ Military Tanzania	-	349	349
Arusha CC	19,437	6,038	6,038
Arusha DC	6,822	3,011	3,011
Buchosa DC	-	14,856	14,856
Bukoba DC	15,758	13,220	13,220
Bukombe DC	17,566	2,154	2,154
Bunda DC	9,117	3,829	3,829
Busega DC	13,077	3,584	3,584
Chalinze DC	-	5,412	5,412
Chato DC	29,071	3,812	3,812
Chunya DC	21,283	5,191	5,191
Dodoma MC	11,264	11,388	11,388
Gelta DC	62,558	28,018	28,018
Igunga DC	34,471	13,239	13,239
Ilala MC	81,094	26,269	26,269
Ilemela MC	18,313	6,576	6,576
Iramba DC	6,671	1,651	1,651
Iringa DC	20,198	6,729	6,729
Iringa MC	16,202	8,530	8,530
Kahama TC	19,902	25,948	25,948
Kallua DC	34,221	3,973	3,973
Karagwe DC	18,259	4,052	4,052
Kibaha TC	4,846	5,899	5,899
Kigamboni MC	-	3,303	3,303
Kigoma Ujiji MC	16,715	7,001	7,001
Kilolo DC	17,032	7,196	7,196
Kilombero DC	13,671	16,360	16,360
Kilosa DC	15,669	10,333	10,333
Kinondoni MC	110,777	15,386	15,386
Kishapu DC	22,029	6,232	6,232
Kwimba DC	33,217	4,304	4,304
Kyela DC	15,529	21,286	21,286
Ludewa DC	14,999	5,323	5,323

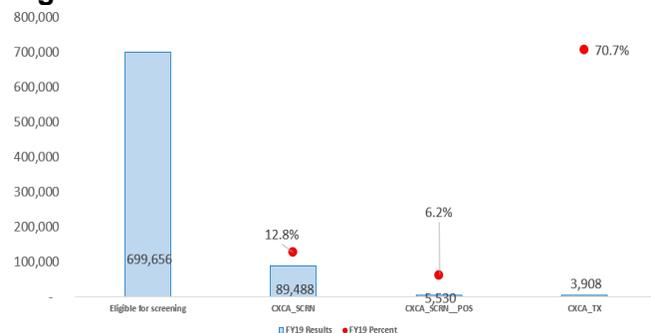
Mafinga TC	5,570	2,729	2,729
Magu DC	23,614	5,869	5,869
Makambako TC	11,397	2,171	2,171
Makete DC	9,821	6,364	6,364
Masasi DC	3,494	2,886	2,886
Maswa DC	22,568	6,375	6,375
Mbarali DC	22,189	22,936	22,936
Mbeya CC	36,182	43,481	43,481
Mbeya DC	21,346	11,454	11,454
Mbinga DC	20,045	16,792	16,792
Mbinga TC	-	13,206	13,206
Mbozi DC	32,000	13,309	13,309
Missenyi DC	10,708	4,006	4,006
Misungwi DC	28,346	5,471	5,471
Mjini	367	1,832	1,832
Mkuranga DC	8,467	7,863	7,863
Momba DC	14,218	2,277	2,277
Morogoro MC	14,017	16,550	16,550
Moshi DC	17,826	10,003	10,003
Mpanda MC	-	3,319	3,319
Msalala DC	-	30,894	30,894
Mufindi DC	21,656	10,892	10,892
Muleba DC	29,833	68,251	68,251
Mvomero DC	10,232	8,796	8,796
Njombe DC	9,597	6,978	6,978
Njombe TC	14,672	7,683	7,683
Nkasi DC	11,267	4,113	4,113
Nyamagana MC	19,148	13,736	13,736
Nzega DC	42,487	15,119	15,119
Rorya DC	6,355	6,723	6,723
Rungwe DC	22,033	9,539	9,539
Sengerema DC	52,550	9,890	9,890
Shinyanga DC	27,269	40,120	40,120
Shinyanga MC	13,485	17,740	17,740
Songea DC	9,503	11,413	11,413
Songea MC	19,871	16,802	16,802
Songwe DC	-	3,295	3,295
Sumbawanga DC	11,709	8,912	8,912

Sumbawanga MC	8,311	9,549	9,549
Tabora MC	20,449	19,099	19,099
Tanga CC	18,991	7,143	7,143
Temeke MC	93,214	20,182	20,182
Tunduma TC	10,003	1,990	1,990
Tunduru DC	16,238	11,560	11,560
Ubungo MC	-	18,726	18,726
Ushetu DC	-	34,842	34,842
Uvinza DC	13,100	2,553	2,553
Uyui DC	34,589	5,692	5,692
Wanging'ombe DC	17,512	5,692	5,692
Grand Total	1,576,017	925,989	925,989

4.8 Cervical Cancer Program Plans

In FY19, 481 sites offered cervical cancer screening and treatment services. A total of 89,488 eligible WLHIV aged 15-49 (12.8%) were screened (See Figure 4.8). Despite not having a set aside budget and targets, many regions performed well on cancer screening in FY19 compared to the previous year. This was due to fact that PEPFAR/T messaging to (IPs changed to emphasize the OGAC requirement to report cervical cancer screening (CCS) indicators even without targets. IPs targeted high-volume sites; these implementing sites had integrated, in situ, the 'screen and treat' services (visual inspection with 5% acetic acid -VIA, cryotherapy and skilled staff) for precancerous lesions, within the CTCs and/or RCH sections.

Figure 4.8



The data source for these indicators are the health facility cervical cancer screening register, treatment forms and monthly aggregated register. The screening register captures client's biodata, cervical cancer screening variables, and HIV status. Data quality issues that will be addressed in COP20 include capturing of cervical cancer screening and treatment cascade for women who are referred for Loop

Electrosurgical Excision Procedure (LEEP) services to avoid double counting along the cascade.

Main challenges facing cervical cancer screening services in Tanzania include (1) lower number of HCWs trained on cervical cancer screening and pre-invasive lesions management, (2) shortage of supplies, (3) data management issues (inadequate data accuracy), and (4) few numbers of mentors to improve the quality screening and pre-invasive lesions management. To address these challenges, PEPFAR/T IPs, in collaboration with Council Health Management Team will conduct outreach services to sites with no cervical cancer screening services by service providers, support facilities in data management, review, and use. PEPFAR/T plans to support coordination of the National Cervical Cancer Screening Program (CECAP) TWG, to closely monitor the implementation progress among high volume sites in high-disease burden regions.

In COP20, it is expected that 50% of the eligible clients will be screened in facilities that contribute to 80% of clients currently on treatment (see Figure 4.8). Primary beneficiaries of the

cervical cancer program will be women living with HIV aged 25-49 years. These women are mobilized and educated on the importance of cervical cancer screening and its close association with HIV. To achieve this goal, a total of \$2 million has been allocated for cervical cancer services in Tanzania. In addition to that, all clinical partners will integrate cervical cancer screening for HIV+ women into routine HIV treatment services. A “screen-and-treat” approach will be implemented for the management of precancerous lesions to maximize opportunities for immediate cryotherapy treatment. PEPFAR/T IPs will implement visual inspection with 5% acetic acid (VIA) as a single-visit ‘point-of-care’ clinical screening for early detection of cervical cancer and clients will be managed using cryotherapy treatment and excisional treatment approaches such as LEEP for cryotherapy ineligible lesions. Women with suspected invasive cervical cancer in places where LEEP services are not available on-site, will be referred for additional evaluation and treatment at established referral sites in the country. Before the referral, the health care worker will determine the women’s level of understanding as to why she is being referred for LEEP before proceeding with counseling and referral. The health care worker will be responsible to review the referral form and fill all required information either electronically or in writings. The referring sites will use the existing Tanzania’s feedback mechanism to ensure all women referred for LEEP services reach and access all required services.

In addition, PEPFAR/T IPs will also focus on capacity building among HCW in screening and treatment of cervical cancer. IPs will support training and mentoring of health care workers, will implement CQI, support availability of commodities, and procure/repair and maintain machines to support effective ‘screen and treat’ in situ. Funds will also support sample transportation systems and will support information, education and communication efforts and awareness raising in collaboration with the Ministry of Health, Community Development, Gender Elderly and Children. The Tanzanian National guideline advocates for screening for all eligible women for cervical cancer regardless of their HIV status. PEPFAR/T will provide clear instructions to IPs to prioritize their efforts to women living with HIV.

4.9 Viral Load and Early Infant Diagnosis Optimization

PEPFAR/T has rapidly increased community VL suppression in the past year through progress in identification, linkage and retention, and VL suppression. Currently, there are 20 VL/EID testing laboratories. Specimen collection and transportation are done through the hub and spoke sample transport system. All health facilities (spokes) have been mapped to a total of 309 hubs, and 303 (98%) of these hubs have been equipped with an electronic sample tracking system (eSRS). Efforts are underway to link VL results with client level information in CTC3, which will facilitate automatic results return to the clinics/facilities. During COP20, PEPFAR/T will continue to support timely VL/EID test result return and utilization, striving to reduce turnaround time to improve efficiency; optimization of laboratory VL/EID testing services, including improvements on specimen transport and results return system; tracking turnaround time (TAT); optimal placement of VL/EID testing platforms; and improving supply chain management. Technical assistance will be provided to support and improve the laboratory information system (LIS), electronic sample referral system, and dashboard for VL/EID and TB. QR code technology will be used to facilitate sample tracking and result return in addition to linkage of VL/EID lab results with patient-level CTC3 database.

In collaboration with MOH, PEPFAR/T will monitor data driven utilization of Point of Care Testing (POCT) for VL, EID and TB testing in hard to reach councils and priority populations. Of the 238 GeneXpert platforms that were procured through the TB program, there are currently 27

GeneXpert platforms doing VL/ EID and TB testing. In COP20, PEPFAR/T will use 91 GeneXpert platforms for EID testing; these machines are already in country. POCT based TB/HIV testing will be data driven to complement conventional platforms in order to ensure reduction in TAT for VL/EID and TB results leading to timely patient management.

PEPRAR/T will focus on client centered services and utilize high-quality treatment literacy approaches including U=U to achieve undetectable viral loads through treatment adherence. PEPFAR/T will continue to ensure that clients with high VL results will receive adherence counseling, be offered a second VL test, and appropriate action thereafter implemented as per the national VL testing algorithm. In COP20, PEPFAR will support NACP by procuring VL reagents and consumables for all VL tests.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

5.0 Critical Systems Investments for Achieving Key Programmatic Gaps

PEPFAR/T COP20 systems investments build on previous years PEPFAR investments and FY20 program shifts and achievements. The main program shifts in COP19 were focused on ensuring rapid progress in finding PLHIV, effectively linking them to care and retaining them on life-saving anti-retroviral treatment, reducing HIV-related morbidity and mortality, and breaking the chain of HIV transmission (U=U) to achieve sustained epidemic control. To sustain the gains achieved so far requires consistent use of data to measure progress and to guide real-time adjustments to ensure that the right strategies are implemented through effective utilization of health workforce supported by training, mentorship, and provision of client centered services in order to improve the quality of HIV services and ensuring focused communities of practice are reaching the right people in the right places at the right time.

In COP20, PEPFAR/T systems investments will focus on addressing key systems barriers identified which include the following:

- Inadequate linkage between patient-level facility data and logistics information system for effective management of ARVs and commodities,
- Inefficient systems and resources for import, product registration, clearance, and distribution of commodities under new policy mandates,
- Insufficient public resource commitments and expenditures to meet national HIV program needs for epidemic control,
- Inefficient use of resources and weak public financial management (PFM) systems that result in low execution rates and poor matching of payments to priority services,
- Inadequate capacity to manage diagnostic network optimization for VL, EID, and TB, supply chain modernization and laboratory quality management including the fidelity of the lab/clinic interface,
- Inadequate number of competent HRH to deliver quality team-based care services for differentiated service delivery modalities in facility and community sites,
- Inefficient system for HCWs prioritization, recruitment, production, allocation, and retention across priority service delivery sites,
- Slow adoption and implementation of key evidence based policies, guidelines and procedures to facilitate rapid scale up and implementation with fidelity of ART optimization, Viral Load/Early Infant Diagnosis optimization, HIV self-testing, PrEP, TB Preventive Therapy (TPT), Differentiated Care Service Delivery Models, Multi Month

Dispensing, use of lay workers, biometric unique identifier, and other key strategies across scale up councils and key populations

- Gaps in surveillance and program data (i.e. data quality and completeness, HI systems) impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels and improve patient-level service delivery and monitoring, and
- Lack of strategic engagement of faith based and private sector for achieving epidemic control and shortage of market segmentation/total market approach.

PEPFAR/T COP20 systems investments are strategically focused to support accelerated progress toward achieving epidemic control and build on foundational building blocks of prior years of PEPFAR investments. They are focused on increasing impact; optimizing alignment of above-site activities and partner management with site level implementation and strategic priorities to ensure key policies rapidly reach patients and maximizing return on investment.

5.1 Information Systems and Data Use

Data and Systems are two of the three foundations for PEPFAR/T FY21 approach to support continuous quality improvement and ability to measure impact for Tanzania's COP20 implementation plans to achieve sustained epidemic control. To implement these strategies, programs need systems and processes that support new capabilities to use data to drive program performance. A key focus of COP20 planning is to expand use of client level data systems at the facility level to concurrently support data needs for program planning and monitoring and to support new clinical processes that enable a person-centered approach.

For COP20, the specific key barrier identified as contributing toward the gap are highlighted in the Table 5.21.

Table 5.1: Key barriers related to health information systems

Epidemic Control Barrier or Systems Gap Identified	Current status (value from investment to date) (2018 Results)	Key selected activities and benchmarks (2020 Plans)
<p>Gap in surveillance and program data (i.e. data quality and completeness, HI systems) impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels and improve patient-level service delivery and monitoring.</p>	<p>Surveillance -Recency testing initiated in 15 phase 1 facilities and CTC2/3 updated to support data management and use.</p> <p>Data Systems -CTC2-CTC3: Improved data quality, Improve security, Improved capacity to analyze and use client level data for CQI processes. -NHCR software development ongoing. -New design of KVP tools -HIM supporting 4 used cases and integration with NHCR and Hospital Systems for HIV Testing ongoing. -Decentralized Death Registration concept developed, and system rolled out in 2 regions.</p> <p>Data Quality -Collaborative approach between PEPFAR and GoT to analyze client level data, identify and address data quality and completeness within CTC2/3</p> <p>Data Use -Leveraging new analysis of client level data to implement Continuous Quality Improvement (CQI)</p>	<p>Surveillance -Produce consensus estimates on key population size and HIV prevalence. -Implementation of recency testing within the highest burden facilities for HIV.PHIA/THIS</p> <p>Data Systems -98% of TX_CURR client data in CTC3 -60% of C&T clients records linked Client Register -Majority of priority councils with interoperable integrated hospital system, DHIS2, eLIMS, through Muungano and HIM -Increased capacity for facilities to enter data directly into Open LMIS</p> <p>Data quality and Data Use -ECHO ->80% of SNUs utilizes qualitative and quantitative data to inform policy implementation toward client centered care</p>

5.1.1 Information Systems and Data Use Achievements to date

Tanzania’s Information Systems and Data Use investments have successfully delivered information systems capabilities that support program data collection, management, and use at all levels which has supported capabilities to consistently monitor and strengthen program to achieve FY20 results to date. Through FY19 and the first half of FY20, client level data systems have improved capabilities to use data, which is driving the program performance. Data system investments are also supporting new clinical processes that are enabling new Person-Centered Approach.

Data Coverage, Analysis and CQI

Within the planning processes for COP19, PEPFAR/T initiated improved use of existing client level data, as evidenced by Tanzania’s ability to calculate new monthly definition of TX_CURR and assess the impact of this change in definition over previous years. Over the past year, Tanzania has continued to use of client level data and introduced new national (CQI) processes together with GoT. This improved use of detailed data, data quality, and identified new opportunities for system improvements. Tanzania has upgraded its systems, strengthened data security, data management and data access systems and processes, and improved on its ability to uniformly analyze client level data. This is a continuous process, but the results have already greatly strengthened Tanzania’s ability to use client level data to drive program results.

Some recent examples of analysis from this client level data includes the program’s ability to analyze the source of loss to follow up and understand how this has been impacting net program current on treatment. Within this analysis, Tanzania has shown it can move beyond

aggregate measures and ensure consistency in definition and criteria for inclusion or exclusion across all facilities.

Clinical process mapping to support person – centered approach

Through FY19 and first half of FY20, with support from above site TA partners, Tanzania has refined its approach to systems analysis and clinical process mapping and documentation to inform system requirements. These requirements are being used to strengthen system design and improved ability of systems to consider clinical process needs and person-centered approaches.

Some examples of new capabilities as a result of these investments include improved patient tracker, appointment reminders, remote check in, and community to facility referral support. Patient tracker refers to the ability for HIV C&T facilities to get feedback when clients start attending another clinic to receive treatment. As a result, they are not counted as loss to follow up, and clinics do not waste valuable resources trying to follow up in the community. M-Health platform and the Community System are supporting m-health interventions like appointment reminders that have been proven to improve appointment attendance and drug adherence.

Systems Interoperability

The PEPFAR/T COP recognizes data systems investments need to drive HIV program performance. PEPFAR/T is working closely with GoT, many other development partners, and across the health sector to ensure the systems investments align with GoT digital health strategies and plans for interoperability. PEPFAR/T partners are working to integrate HIV system requirements into national health information systems for sustainability. This alignment, along with health systems strengthening, results in systems that support HIV program goals while concurrently supporting, strengthening, and aligning with the evolution of wider health system. Tanzania is moving towards an architected set of solutions that builds national capacity and supports sustainability.

The MOH and eGOV Agency approved a National Health Client Identification Standard and development of National Health Client Register that is progressing well. The Health Information Mediator successfully implemented four initial use cases for national hospitals, including client level data exchange, aggregate data exchange, health facility data exchange, and hospital reporting. These are supporting MOH with actional insights into the functions of national hospitals.

PEPFAR/T is investing in strengthening national registries, data repositories and the Health Information Mediator to achieve the systems and data interoperability the health sector and HIV epidemic control need. In FY20, PEPFAR/T will continue to support the development and use of the National Health Client Register to achieve the Tanzanian health identification strategy. Tanzania has ambitious plans to build on these successes and to further support HIV-related programming.

5.1.2 Information Systems and Data Use Priorities and COP20 Activities

Moving forward into COP20, Tanzania will continue to build upon capabilities that leverage client level data systems to achieve program performance targets. In addition to data use, the PEPFAR/T's COP20 planned above site investments and activities will support new clinical processes that enable Person-Centered services.

Clinical process mapping and system features to support person centered services

As PEPFAR/T look for opportunities to expand person-centered services and ensure systems are meeting programmatic needs, teams are re-thinking the system development processes. New system development efforts are working to link SOP, M&E and information system development efforts and emphasizing clinical process mapping and requirements documents. Through FY21, above site partners are being tasked with leveraging this work to identify and scale new interventions by incorporating them into information system processes. For example, teams have seen success with the Front Desk Approach to reviewing client records to ensure all appropriate interventions or clinical processes have been implemented. Above site partners will be taking these best practices and updating systems and standard processes to support their implementation at scale. In FY21 partners will begin using new capabilities supported by information systems to strengthen systems and services such as increased capacity for facilities to enter stock data directly into electronic Logistics Management Information System (eLMIS). An increased number of facilities will be making use of automated SMS appointment reminders, remote check in, and SMS IEC. Improved connectivity between community and facility systems will be leveraged to support referrals, improve confidential index case/contact tracking, tracking lost to follow up patients, and identification of new cases.

Patient Monitoring

Tanzania is currently using program data for patient monitoring and is continuously strengthening national and subnational systems to support long term sustained epidemic control. The NACP Patient Monitoring System (PMS) includes modules for HTS, treatment, pharmacy, and recency. For HIV Treatment services, the NACP PMS has already achieved 95% coverage of TX_CURR and supports capture and use of visits, drugs prescribed, opportunistic infections, and viral load status. Tanzania will gradually increase data capture of HIV testing to reduce burden on facilities. HIV services are leveraging data to identify clients that are lost to follow up, and facilities are being tasked with ensuring that status is appropriately updated to capture current status. As interoperability of systems continues to grow, patient-level monitoring will improve clinical service delivery. Tanzania is also working to address unique identification and deduplication capabilities and support for secure data access analysis across the operating unit.

Data Security and Confidentiality and Client Level Data for HIV Prevention Services for KVP

While data security and confidentiality are always a vital concern, the recent scale up of index testing and plans to scale PrEP services for KVPs and use of client level data is increasing the risks associated with managing and using data to monitor and improve programs and deliver person-centered services. In FY20, NACP and above site partners have completed a detailed review of KVP screening tools, KVP service registers, and PrEP client tools. The aim of this review is to carefully plan approaches and new tools that support monitoring, program performance and person-centered care while working to also protect KVPs from stigma, discrimination or other adverse events. A recent driver of program performance has been the scale up of index testing. Over the coming year, Tanzania will roll out these new tools and develop data systems to support their implementation and data use. Screening tool and register will identify KVP type but will not track individual identity. NACP is also introducing a new HIV Prevention Client card that will support person-centered care and follow up for PrEP services but will not include KVP type. This approach emphasizes the key principle in PEPFAR

monitoring, evaluation, and reporting guidance (MER 2.0 [version 2.4]) that the priority of data collection and reporting of program data for key populations must be to do no harm. Civil society partners and groups will be engaged to help educate stakeholders on protections, roles, and responsibilities.

Above site investments in data and systems have improved capabilities that have made recent programmatic achievements possible. PEPFAR/T COP20 plans are building on these foundations to deliver new capabilities and drive FY21 program performance.

5.2 Human Resources for Health

In COP20, PEPFAR/T HRH investments are strategically focused on addressing HRH gaps and barriers to ensure that the right health workforce has the required competencies to deliver services to support high quality HIV prevention interventions and treatment services to improve the health of PLHIV and to support accelerated progress toward achieving HIV epidemic control. PEPFAR/T will continue to support investments geared towards increasing the quantity (number) and quality (competence) of health care professional cadres, to ensure a standard and appropriate skill mix, in alignment with health facility levels and national staffing norms.

HRH investments will continue to contribute towards the overall PEPFAR/T HRH strategy consisting of 5 objectives namely (1) consider HRH capacity and needs, (2) develop site level supply strategies, (3) improve site-level recruitment, deployment and retention, (4) establish sustainable financing of HRH, and (5) improve site level HRH performance; and will be focused on the following priorities:

- 1) Support efforts to increase number (through hiring- monitored by the annual HRH_CURR indicator) of health care professionals with the required competence (through collaborative learning approaches; in-service training using telehealth services such as ECHO, e-learning models, etc.) to provide quality of HIV services, while also ensuring the GoT commits to absorb the PEPFAR/T supported HCWs, as part of HRH sustainability approach.
- 2) Support improved retention, deployment, and redistribution of health care workers (facility and community level) and ensure proper allocation of HCWs, including skill mix determination (using evidence-based HRH tools such as WISN-POA-WAO).
- 3) Strengthen professional development (through CPD considering their respective career paths, & working with professional associations and professional councils/regulatory bodies to reinforce, sustain investments, and maintain quality of HIV services).
- 4) Support advocacy for increased budget allocation (HRH financing) according to needs and HRH data utilization (supportive evidence).
- 5) Increase use of data for decision making (e.g. epidemiological pattern changes, THIS, KVP studies), demographic profile, policy shifts, infrastructure changes (increasing number of health facilities/new site providing HIV services), to fully utilize already developed and integrated capacity of HCWs. This will include reviewing the Human for Health Information System (HRHIS) to capture indicators that will support the design of an HRH cascade.

For COP20, the specific key barriers identified as contributing toward the gaps are highlighted in the Table 5.2.

Table 5.2: Key barriers related to human resources for health (HRH)

Epidemic Control Barrier or Systems Gap Identified	Current status (value from investment to date) (2019 Results)	Key selected activities and benchmarks (2020 Plans)
<p>Inadequate number of competent HRH to deliver quality team-based care services for differentiated service delivery modalities in facility and community sites</p>	<p>Draft National Health Sector e-Continuing Professional Development (e-CPD) coordination framework developed</p> <p>Development of Learning Management System (LMS) at CDE to host the in-service field epidemiology training intermediate course (cohort 5)</p> <p>http://tzcdc.ghelarning.org/</p> <p>Training modules for mid-level cadres to undertake task sharing roles developed</p> <p>Training of nurses on nurse initiation and management of antiretroviral therapy (NIMART) and training of other HCWs per the task sharing policy</p>	<p>Activities</p> <p>Strengthen, expand social welfare workforce and monitor performance including transitioning of workforce to Local Government Authorities (LGAs) in 84 councils</p> <p>Provide technical support to NACP and other IPs to monitor and track efficiency of implementing various DSMs, focused on adolescent and pediatric outcomes.</p> <p>Build on the previous HRH inventories of PEPFAR HRH support to address the chronic HRH shortages for HIV service delivery</p> <p>Continue to provide technical support to MOH in implementation of a retention plan to assist to reduce the vacancy rates</p> <p>Support for HRHIS Assessment Framework (HAF) implementation, as part of the business model for interoperability</p>

5.2.1 Human Resources for Health Achievements to date

According to the MoHCDGEC FELTP Strategic Plan 2016 -2020, it is estimated that Tanzania requires 225 epidemiologists (1 per 200,000 populations). However, most trained epidemiologists are located at the national level, leaving approximately 55% of required positions vacant. This gap contributes directly to the inability to effectively monitor and evaluate ongoing HIV/AIDS programs or detect other priority diseases. As of February 2020, the FELTP program has trained 450 health care workers in Field Epidemiology and Laboratory management that are in multiple regions and districts within the country. These individuals are responding to public health emergencies and building and evaluating surveillance systems. For COP20, the FELTP graduates and residents will assist with conducting/supporting monitoring and evaluation of progress towards HIV epidemic control through real-time data analysis for public health action, data quality improvement, and HIV surveillance-based activities. Fostering the FELTP program is a collaborative effort between clinical implementing partners and CDC staff. More importantly, it is a part of the mentorship model to assist in building skills of residents and enable transfer of knowledge on current HIV related interventions.

In July 2018, PO-RALG used WISN+POA analysis tools to distribute 6,180 HCWs to all LGAs and mentored them to use evidence-based analysis to allocate these health workers to health facilities. 21 out of 93 LGAs that were assessed demonstrated application of WISN+POA tools for allocation of HCWs by 80% - 100%. This approach has been adopted by GoT and in COP18, WISN + POA will be institutionalized into GoT systems. In COP19, PEPFAR/T upgraded the IT platform for institutionalization of WISN + POA + WAO into interoperable GoT systems including HRHIS and DHIS. This will include integrating WISN+POA to the Planning and budgeting system (PlanRep) for matching HCWs with council resources. The goal of continued use of the HRH tools are to inform deployment at the central level- Presidents Office

Public Service Management (POPSM), to determine HRH needs at the facility & LGA level and provide analytics of HRH need and supply in relation to available resources. PEPFAR/T in COP20 will continue to build on the progress from the previous years to ensure institutionalization of the various tools with the goal of ensuring interoperability with the HRHIS, as part of the business model designed.

PEPFAR/T's strategy to address misdistribution and misallocation of existing health workers is implemented through a coordinated approach that engages POPSM, MOH, PO-RALG and Ministry of Finance and Planning (MoFP). These strategies are also in response to specific HIV policy and program requirements, i.e. Test and Start, DSM, self-testing and surge needs related to unique site level monitoring in scale-up councils to meet key targets.

5.2.2 Human Resources for Health Priorities and COP20 Activities

PEPFAR/T will continue to focus on host country institutional development for HRH leadership, governance, and management. PEPFAR/T will ensure that at least 75% of HCW are retained for one year using the information available in the HRHIS to monitor progress. This will be done through continued technical support to GoT (MoHCDGEC & PO-RALG). PEPFAR/T will support the MOH in increasing recruitment, retention, and allocation of health and social welfare workers at all levels based on the HRH strategy, using various approaches and models such as NIMART and DSM.

To improve HRH retention rates, PEPFAR/T will employ a combination of methods to ensure a decrease in vacancy rates through the various components of the HRH cycle. Facilities will continue to modify retention plans using key HR metrics on attrition rates, staff turnover, and absenteeism. In COP20, PEPFAR/T will continue to build on the previous HRH inventories to address the chronic HRH shortage for HIV service delivery through a local partner initiative that identifies innovative and sustainable solutions to HRH recruitment, deployment, and transition to GoT public service. In addition, for COP20, PEPFAR/T will strengthen performance management of health workforce and develop customized retention packages in 185 LGAs, to support test and start, acceleration of differentiated service delivery models, and acceleration of TPT services.

COP20 will continue to support mid and lower-level cadres through translation of the task sharing policy into operational practice, including supervision and mentorship and induction trainings for tutors in zonal health resource centers. Monitoring of trained HCWs, as identified in the task sharing policy, will be done through the USG supported-Train SMART tool. PEPFAR/T will support the development of monitoring and evaluation tools to guide implementation of task sharing and ensure compliance and quality control. The monitoring framework will utilize success stories, best practices for shared learning, and guide decision making among key stakeholders with regards to PEPFAR/T priorities.

In addition, PEPFAR/T will continue to support lay cadres in provision of HTS under the task sharing policy implementation and NIMART. This will include expanded task descriptor analysis for potential expansion/intensification of HCWs roles and tasks (e.g. nurses, lay cadres) in key HIV areas to ensure effective utilization of available HCWs in terms of time and task management. This will also include proper allocation of available expert clients required for BCPE linkage case management model scale-up, LTFU response, with possible modification and alignment to remuneration and job descriptions. PEPFAR/T will support the continued utilization of the Tanzania Nursing and Midwives Information System and a full roll out of NIMART.

In COP20, PEPFAR/T will continue to work with NACP and other development partners to further identify and align with the HRH priority areas all the while taking into consideration epidemiological and geographic shifts. The residents and graduates of the FELTP will focus on PEPFAR/T technical issues, programmatic challenges, and shifts. They will also concentrate on supporting data quality and surveillance-based activities, in addition to supporting the utilization of the emergency operation center for real-time data analysis for public health action.

PEPFAR/T will support the scale-up of virtual communities of practice through the expansion of Project ECHO Tanzania and continue to build on the established Centre for Distance Education (CDE) e-learning platform and HIV module development to strengthen implementation of key strategies. This will allow acceleration in the scale-up of DSMs and test and start. It will ensure standardized training support to clinical mentors and expanded access to virtual learning support at the site level. In addition, it will strengthen capacity of HCWs for effective data utilization to support evidence-based decision making for public health impact at all levels of the health systems that contribute to ensuring high quality HIV service delivery through on-the-job, competency-based tiered field epidemiology training.

In order to achieve efficiency gains in implementation of key policies and strategies, PEPFAR/T will continue to leverage efforts through partners during implementation of various strategic plans, such as the Human Resource for Health draft strategic plan 2020 – 2025 and Digital Health strategy 2019-2024. The strategic priorities within these documents and others are complementary, and they align with PEPFAR support areas.

5.3 Laboratory Systems

The national health laboratory system in Tanzania operates as a six-tiered network of health laboratories. It is comprised of a National Health Laboratory (National Health Laboratory Quality Assurance and Training Center - NHLQATC, four zonal referral laboratories, four specialized hospital laboratories, 29 regional level laboratories, 130 district level laboratories, and 583 laboratories in health centers). In all of these laboratories, PEPFAR/T supports scale-up of HIV viral load testing for routine monitoring and EID services that include access, uptake, documentation of final diagnosis, sample transport networks, and a results return system using a spoke and hub system to transport the samples from facilities to testing labs.

PEPFAR/T supports EQA/PT program, certification program, and laboratory quality management to ensure accurate, timely, reliable test results through continuous quality improvement and accreditation of laboratories, as well as continuous quality improvement for HIV rapid testing, TB and recency testing. PEPFAR/T supports access to testing for HIV and tuberculosis through diagnostic network optimization and multiplex use of platforms to increase equipment utilization for better management of diseases.

5.3.1 Laboratory Systems priorities and COP20 activities

PEPFAR/T will focus on addressing the COP20 identified gaps to increase VL coverage and quality of testing. This will be done through (1) elimination of barriers that hinder scale-up of VL coverage and timely return of results for patient care, (2) accreditation of viral load testing laboratories to international standards ISO 15189, (3) progressive improvements to laboratory Information Systems, (4) optimization of dashboard for VL, EID, and TB, and (5) continuous scale-up and quality improvement of HIV Rapid Testing.

In collaboration with MOH, PEPFAR/T will monitor data driven utilization of Point of Care Testing (POCT) for viral load, EID, and TB testing in hard to reach councils and priorities

population. The POCT equipment will be placed strategically to complement conventional platforms in order to ensure reduction in turnaround time for VL/EID and TB results leading to timely patient management.

PEPFAR/T will focus on client centered service and utilize high-quality treatment literacy training approaches to help achieve undetectable viral loads through treatment adherence. Also, PEPFAR/T will continue to ensure that clients with high VL results receive adherence counseling, offered a second VL test, and advised on the appropriate action thereafter per the national VL testing algorithm.

5.4 Policies and Governance

Policies that are critical to reaching the country's targets include those related to HIV self-testing, PrEP, differentiated care service delivery models, same day ART initiation, and multi-month dispensing. Same-day ART initiation has been scaled-up and circulars were released to change from 14 days to within seven days in May 2019. Among eligible clients enrolled on care, 97% are initiated on ART within seven days. On the contrary, multi-month dispensing has been scaled up with 77% of eligible clients receiving at least three months ART. Dar es Salaam region began implementation of 6MMD in February 2020. The recently amended HIV and AIDS Prevention and Control Act (HAPCA) allows self-testing in adults and lowers age of consent from 18 to 15 years. Optimized ARV regimens for both adults and pediatrics has been rolled out to all supported facilities.

5.4.1 Policies and Governance achievements to date

Following the release of the THIS 2016-2017, PEPFAR/T has supported GoT efforts to adopt new policies to increase identification, linkage, and retention. PEPFAR/T worked closely with the GoT to provide additional findings to support policy development and engagement with other stakeholders to develop a policy implementation plan. Test and Start is implemented in all care and treatment facilities with 97% of newly diagnosed positive initiated on ART within seven days. Index Testing is being scaled up with a focus on fidelity with monthly monitoring implemented to track progress, and implementation of 6MMD is underway in one region. The experience will guide further scale up in other regions. In addition, NIMART guidelines have been approved, trainings have been conducted, and tracking of impact on initiation has been put in place. The GoT plans to conduct an assessment and mapping of unemployed medical trained personnel to support HIV testing activities. GoT and PEPFAR/T have agreed to use unique patient identification with biometric finger scanning as one of the components for the unique ID. HIV Data system draft documents and the requirements are being finalized. Throughout these policy processes, the GoT has demonstrated an increased political will to promote client centered care. After the HIV law revision, the GoT is in the process of developing regulations and framework to guide roll out of HIV self-testing countrywide. Phased implementation has started in three regions of Mwanza, Njombe and Ruvuma. PrEP has been integrated into the combination prevention intervention after the demonstration project. It is currently being implemented in nine regions, and plans to scale up are underway.

5.4.2 Policies and Governance priorities in reaching and Sustaining Epidemic Control

Since 2017, there has been policy development to support priorities that will lead to sustaining epidemic control. However, most recently (late 2017- 2018), there have been protracted decision making processes and weak implementation of key laws, policies, guidelines, and procedures to facilitate rapid scale-up of ART optimization, EID, self-testing, community ART,

TPT, DSM, MMD, index testing, and other key strategies across scale-up councils. PEPFAR/T has been working closely with the GoT to build on recent momentum in policy progress and articulate stronger commitments to implement policies in all service delivery sites. The USG will continue to hold regular meetings with senior Ministry of Health Officials to track progress in policy commitment, development and implementation, along with other key epidemic control priorities identified in COP20 guidance and program data, and on a quarterly basis will engage with MOH leadership (including the Deputy Minister of Health and the Minister of Health) to identify any challenges for action. In COP20, PEPFAR/T will continue to support national and sub-national structures including the RHMTs and CHMTs in translating policy guidelines into annual operational plans and provide continuous monitoring support for effective implementation.

In COP20 PEPFAR/T will provide technical support to NACP and other IPs to monitor and track efficiency of implementing various DSMs including, Test and Start, same day initiation, and six-month dispensing in selected regions with three months dispensing countrywide. PEPFAR/T will continue to strengthen capacity of the National PMTCT team to monitor eMTCT progress using new M&E systems and create a system that enables utilization of service level data in a real time to inform policy recommendations and resource prioritization at National and Sub-national.

Clinical HIV service delivery and M&E tools and approaches will be standardized for rapid cascading translation of policy into practice and support to MOH to develop guidance for increased access to HIV Self Testing such as use of automatic dispensers/vending machines in key hotspots and community locations.

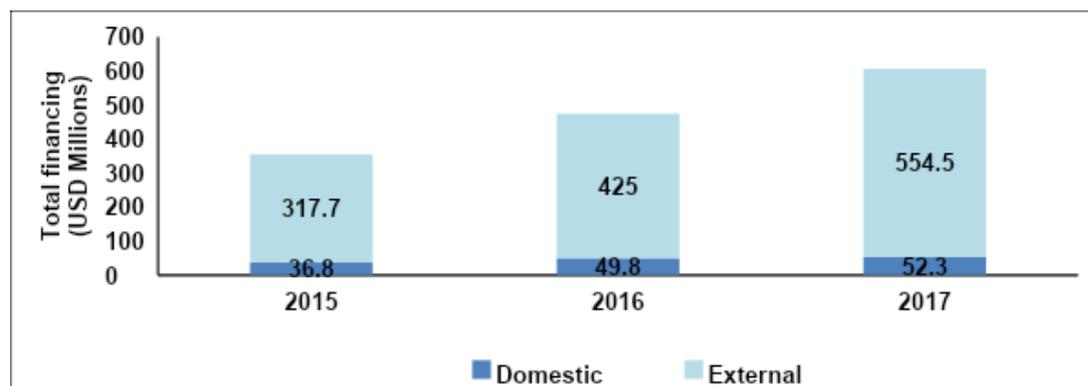
For women, adolescent, and pediatric care, PEPFAR/T will support oversight and monitoring of rollout of the transition to DTG for women of reproductive age and adolescents. PEPFAR/T will also scale up adolescent psychosocial support services and specialized services for pediatric and adolescent PLHIV. In addition, PEPFAR/T will develop guidelines and SOPs for the rollout of pediatric ARV optimization, including support to strengthen and monitor clinical services for CLHIV using QI approaches and real-time data monitoring for programmatic action.

GoT policy around customs clearance and VAT application for the import of medical products remains a key concern. Publicly funded, privately financed, and donated products are all impacted by regulations on international import and goods clearance. PEPFAR/T continues to work with the GoT to identify challenges in this area and will provide some support to the pharmaceutical regulatory sector to ensure quality and identify areas where policies and processes can be streamlined. Clear, fast, and consistent import processes mean that life-saving health commodities, such as ARVs, can reach patients faster, consistently, and in the appropriate quality condition. These policies are important for long term sustainable epidemic control.

5.5 Financing

The goal of PEPFAR/T's systems investment in finance is for Tanzania to support sustainable financing for epidemic control. While there were some improvements in the PEPFAR/T SID 3.0 for this domain, the HIV program is largely donor dependent. A recent UNAIDS HIV investment case report indicated that PEPFAR and the Global Fund accounted for 88% of financing in 2015 and 2016 and 90% in 2017, respectively. Several other donors and partners beyond PEPFAR and the Global Fund have provided small amounts of financial support and technical assistance. The graph below depicts the trend in HIV financing over time using data from the TACAIDS and UNAIDS Tanzania HIV Investment Case Report- 2019 (unpublished data).

Figure 5.5: Domestic and external HIV expenditure 2015-2017



Sources: Domestic: Global Fund (2018). National Funding Landscape Analysis. PEPFAR: PEPFAR (2018). PEPFAR Expenditure Report 2017; Global Fund: Global Fund (2018). Global Fund Expenditure Report 2017. Tanzania HIV Expenditure; Other external funders: Global Fund (2018). National Funding Landscape Analysis.

PEPFAR continues to be the largest donor for Tanzania’s HIV program, especially for the funding of national program priorities like care and treatment. According to the UNAIDS Investment case, “PEPFAR contributed USD 290.4 M in 2015, rising by 17% in 2016 and 11% in 2017. PEPFAR accounted for more than 80% of total HIV expenditure in 2015 and 62% in 2016 as expenditure on the Global Fund grant accelerated. In 2016 Global Fund spending rose from USD 21.6 M to USD 80.4 M.”

PEPFAR supports sustainable financing efforts to improve efficient use of existing resources and domestic revenue generation. As part of improving efficiencies, PEPFAR has supported national and local government systems for improved public financial management (PFM). The national budget of Tanzania does include some funding for HIV/AIDS, and increased avenues have been developed for public participation in budget advocacy and formulation. PEPFAR supports strengthened public financial management at the health facilities, and local government authorities improve budget allocation and budget execution. There are enduring systemic weaknesses related to fiscal space, particularly limited resource allocations for HIV from the Total Government Expenditure and inefficiencies in the use of existing resources (Tanzania National Health Accounts 2016/2017). Furthermore, the country’s efforts on the Single National Health Insurance remain stalled through political processes and complicated proposals- like merging of the Workers Compensation Fund to function as a source of pooled resources for health insurance. In COP20, PEPFAR/T will target better PFM systems and interventions across the health financing continuum, with a focus on strategic purchasing. The health financing reforms instituted by the GoT and supported by PEPFAR, as part of the Direct Health Facility Financing (DHFF), have provided the impetus for better outputs-based financing and presents opportunities for providers at local levels to better match payments to priority services.

However as identified though the SID 3.0, sustainable financing remains one of the weakest scores on the sustainability framework, and several challenges exist that impact the country’s efforts at domestic resource mobilization and improved efficiencies in the use of existing resources.

Table 5.5 describes systems barriers, results from the previous year’s investments, and some of the key activities planned.

Table 5.5: Systems barriers related to financing

Epidemic Control Barrier or Systems Gap Identified	Current status (value from investment to date) (2018 Results)	Key selected activities and benchmarks (2019 Plans)
<p>Insufficient public resource commitments and expenditures to meet national HIV program needs for epidemic control</p>	<p>PEPFAR through support to key IPs and local CSOs has continued to support the GoT commitment to Single National Health Insurance. While the operational details are still under political review, the technical work to inform policy, decisions continue through analytical studies and research.</p> <p>The Direct Health Financing Reforms have increased the transparency and flow of resources to the local levels. This has increased provider autonomy and potential for increased governance and accountability.</p> <p>PEPFAR, through the GHSA-TA activity, has completed studies to inform how direct funding at the facility level would improve product availability and reduce stock outs of essential medicines like Cot rim for management</p>	<p>Activities Continue Support for implementation of key components of the national health insurance strategy, the iCHF program roll out, which is managed by the Local Government authorities and have potential for greater coverage for PLWHA.</p> <p>Support NHIF analytics and programming that emphasizes market segmentation and co-payments for paying clients to increase the potential of revenue generation and greater security of the Fund.</p> <p>Increase the support and TA to the NHIF for improved management structures and payment modalities This will also be linked with policy dialogue to inform the benefits package and different premium levels</p> <p>Benchmarks</p>

	<p>of OIs for people living with HIV/AIDS (PLWHA)</p> <p>PEPFAR supported activities related to the national launch of the improved Community Health Fund (iCHF), which will be an additional source of revenue for health. National training for ICHF implementation conducted through cascade trainings that focused on enrolment processes, patient management and provider payment methods; and linking insurance data systems with other data management systems.</p>	<p>Proportion of regions that implement improved insurance schemes to generate additional revenue for priority HIV services Proportion of councils that are using updated PlanRep and FFAR tools to inform council level planning for inclusion of priority services including HIV</p>
<p>Inefficient use of resources and weak public financial management (PFM) systems that result in low execution rates and poor matching of payments to priority services</p>	<p>Strengthened LGA and facility level planning, budgeting, accounting, and reporting which led to increased efficiency and accountability in resource management for quality HIV service delivery.</p> <p>PlanRep, - the GoT's web-based tool for planning and budgeting, has been launched nationwide. Council level plans and budgets are done in accordance with the budget guidelines and ceilings issued by MOFP. These practices are fundamental to PFM practices- which in turns increases efficiency in use of public resources.</p>	<p>Activities Increase efficient use of resources at the local level for HIV service delivery, through improved management of Direct Health Facility Financing and support for on time disbursements of resources from Ministry of Finance</p> <p>Improve efficient use of HIV resources by increasing budget execution levels of allocated HIV resources within the GoT national budget</p> <p>Benchmarks Percentage of approved budget transferred from national level to LGA Level</p>

5.5.1 Financing Achievements to date

PEPFAR/T's investments and support for Direct Health Facility Financing (DHFF) Management and public financial management over time has resulted in more efficient GoT systems for budgeting, disbursement, management, and use of funds. The redesigned GoT planning system, PlanRep is now a web-based national platform that is linked to the annual council planning process. This is used together with the improved financial systems-Facility Financial Accounting and Reporting Systems (FFARS), which is a simple accounting system used by service providers to acknowledge receipt of revenue, process procurements, manage expenditures, and produce financial reports for all funds flows.

PEPFAR/T's support for the redesign and launch of PlanRep and the improved financial accounting and reporting systems (FFARS) have led to improvements across all PEPFAR/T's scale up councils to develop, review, and approve annual plans and monitor budgets using more efficient planning and financial systems. This improvement contributes to on-time report submissions and improved availability of quality budget information on HIV expenditures.

Technical assistance provided through PEPFAR/T resulted in a strategic purchasing agreement that shifted DFF for health basket fund from input-based to output-based payments. This achievement was the result of extensive dialogue between PEPFAR/T, the health basket fund donors in Tanzania, and the Government of Tanzania. This reform increased the allocation of domestic funds for HIV services in council level health plans. It also improved the predictability and flow of funds from central to sub-national levels.

PEPFAR/T continues to lead strategic advocacy efforts among key stakeholders for supply chain targeted fund allocation in the GoT budget to mitigate challenges associated with ARV and commodity distribution.

5.5.2 Financing priorities and COP20 finance activities

PEPFAR/T will continue to support and leverage the ongoing GoT financing reforms, including the Direct Health Facility Financing (DHFF) Management system to increase use of public finance for the HIV/AIDS response and increase efficient use of the existing resources. PEPFAR/T support over the past three years has contributed to incremental gains towards improved allocative efficiencies, especially at the lower government levels, which is a key condition for the efficient use of public resources.

PEPFAR/T will continue to support the DHFF as a part of fiscal decentralization in the country. The goal is to create a unifying purchasing framework that refines the different fund flows and DFF payments to the facilities and improve provider capacities to efficiently use these resources to deliver priority health and HIV services. PEPFAR will continue to conduct analytics on financing and other critical system areas to inform efficiencies in use of public resources. As an example, through USAID's Global Health Supply Chain Activity, PEPFAR supported a report that documents the impact of DHFF on the availability of commodities at the facilities. The report indicates that there is an opportunity for greater leverage of these resources to support HIV services that are not funded through PEPFAR, such as increasing the availability of cotrimoxazole for treatment of OI's among PLWHA.

Given the limited fiscal environment, PFM continues to be an area of focus for PEPFAR/T support to address barriers that hamper HIV service delivery and improve overall efficiencies at the local council and facility level. PEPFAR/T will provide support to ensure that the system allowing LGAs to receive on-time disbursements of allocated resources from MOFP to enable HIV service delivery is running smoothly through its second year of implementation.

As a result of these foundational PFM investment, PEPFAR/T will use these financial systems to inform the Activity Based Costing Management ABC/M activity, an OGAC priority which is featured for Tanzania, among three other East African Countries. The Activity based costing is designed to determine baselines of cost estimates for HIV program activities. This will contribute to inform PEPFAR goals for financial and program sustainability by supporting informed resource allocation decisions and maximizing PEPFAR investments. The ABC/M has been launched as a core funding activity, but PEPFAR/T's core IPs, including the Public Sector Systems Strengthening (PS3) and HP+, will support these activities on the ground.

PEPFAR/T will provide TA to the National Health Insurance Fund as a purchaser for national health insurance. The ongoing work on the Single National Health Insurance (SNHI) will continue with extra support for TA to NHIF and support for implementation of the iCHF, which has potential for greater coverage, especially for low income, informal sector populations affected by HIV. In addition, PEPFAR/T will continue support to the regions and districts to ensure effective administration and management – and insurance coverage, especially for PLWHA through the improved community health fund (iCHF).

5.6 Private Sector NEW for COP20

The general business environment is constrained by increasing and constantly changing regulations. This negatively impacts the ability of the private sector to contribute to the HIV/AIDS epidemic. However, there have been some changes in law and regulations pertaining to epidemic control that have created opportunities for leveraging private sector resources, expertise, and networks to achieve epidemic control.

5.6.1 Private Sector Achievements to date

Some of the key private sector achievements over the previous year include:

- *HIV Self-Testing:* In November 2019, Parliament passed legislation allowing HIV self-testing and lowered the minimum age for self-testing to 15 years of age. The law does not restrict private sector sale of HIV self-test kits. TMDA has registered OraQuick and INSTI- and BIOSURE are in the process of being registered
- *Condom Supply and Total Market Approach (TMA):* (a) The TMA HIV commodities core group is using evidence from PEPFAR-funded assessments that shows consumer willingness to pay for condoms and illustrates how untargeted distribution of free condoms will destroy potentially sustainable markets. The TACAIDS subcommittee on condoms has inserted TMA narrative in revisions of the national condom strategy and has connected TACAIDS leadership with private sector suppliers as part of TMA advocacy.
- *HIV In-Service Training and Private Provider Coaching:* The GoT is now routinely empaneling health facilities to be certified sites in-service training for staff and pre-service students doing practicums at these facilities. This was piloted in the private sector and has now been adopted by the public sector. The success of this activity will now be applied to promoting client-centered task sharing at private facilities in hopes that success in the private sector will induce change in the public sector.

Table 5.6: System barriers related to the private sector

Epidemic Control Barrier or Systems Gap Identified	Current status (value from Investment to date) (2019 Results)	Key selected activities and benchmarks (2020 Plans)
Lack of strategic engagement of faith-based and private sector actors for achieving epidemic control and shortage of market segmentation/total market approach	<p>Advocacy led to legislation permitting self-testing</p> <p>Advocacy for TMA has increased GoT and Global Fund awareness of the dangers of long-term sustainability by flooding the market with free condoms</p>	<p>Activities: Continued intervention at GoT national level to enshrine TMA principles in policies and strategies</p> <p>Engage stakeholders at selected subnational levels to implement TMA in condom and HIVSTK distribution</p> <p>Benchmarks:</p> <ul style="list-style-type: none"> # HIVSTKs and condoms distributed through corporate testing model # HIVSTKs and condoms distributed through ADDOs # new male cafes found # young people collecting ARVs at ART sites #/type lower cadre staff participating in task sharing at private facilities % share condom market by commercial providers % share condom market by social enterprise

5.6.2 Private Sector Priorities and COP20 Activities

SID 3.0 scoring does not represent the full picture of private sector investment and environment in Tanzania. Despite some improvements in the score, there remains weak private sector engagement in the response to HIV/AIDS caused in part by regulatory constraints imposed by the GoT. In addition, some epidemic control programs work at cross-purposes with the goal of building a sustainable HIV/AIDS response through the private sector. For example, the proposed massive distribution of free condoms threatens established commercial markets and modestly priced condom markets being nurtured by social enterprise. The fact that the Global Fund-supported program of free condoms in Tanzania has stalled for so long is due, in part, to the success of PEPFAR/T in resolutely championing TMA. TMA advocacy will continue at the national level but in COP20, it will be supplemented by interventions at carefully selected subnational levels where local GoT authorities, private sector capacity, and potential consumer demand present market creation opportunities.

Business unfriendly regulations have induced understandable caution in the private sector. PEPFAR/T interventions in COP20 are intended to spark innovation and informed risk-taking. A clinical coaching program among selected private providers will demonstrate the value of task sharing in providing HIV/AIDS services as specified in the NIMART policy. The intervention will include elements of business and HRH management so that private providers offer client-centered quality care, utilize more fully their lower cadre staff in providing HIV/AIDS care, and develop financially sustainable business strategies.

Based on evidence generated in prior PEPFAR-funded assessments, a private sector ART service model aimed at promoting self-testing and retaining youth on treatment will be piloted around dense and sexually active youth populations surrounding vocational training centers, colleges, and universities. Youth-friendly ART pick-up sites will include a network of private

health facilities, pharmacies, and testing, care and treatment centers. Digital applications and youth-centered messaging that encourage self-referral will be part of the marketing strategy.

Legislation allowing HIV self-testing presents an opportunity to increase case finding among adolescent and young men through the more than 10,000 Accredited Drug Dispensing Outlets (ADDOs). Using E-vouchers at a subnational pilot site, targeted marketing will be used to attract customers who will purchase HIVSTKs and generate the evidence that GoT will require for scale-up.

Male case-finding will be the aim of interventions near and at businesses that are reliant on a male workforce. Given male reluctance to visit health facilities, various modalities will be tested to motivating employed men to test. The intervention will involve creating informal and formal partnerships among HIVSTK providers, businesses, and PEPFAR implementing partners.

5.7 Supply Chain and Commodity Management

PEPFAR/T investments in supply chain capacity to date have resulted in improved efficiency and responsiveness. With support from PEPFAR, the Global Fund, and other stakeholders, Tanzania redesigned its supply chain system in FY18. The new system increases reporting frequency from quarterly to monthly, allowing for more current data for decision-making. Delivery schedules to facilities also increased in frequency, helping to ensure product availability to clients. The new design began national roll out in FY19, and in FY20 is now being implemented in the Mwanza and Tabora zones that cover Mwanza, Simiyu, Shinyanga, Geita, Tabora and Kigoma regions. National rollout will continue in FY21, in collaboration with Global Fund, MOH, and MSD.

The IMPACT team initiative capacitates Regional and District Supply Chain Managers to review and analyze logistics data at facilities with the goal of improving data quality. Improved quality of logistics data contributes to vital and informed decision making to address commodity stock imbalances. Bolstered by the new supply chain system design, PEPFAR will continue to support the IMPACT teams in FY21.

PEPFAR/T investments in supply chain data improvements include the roll out of the eLMIS. Data from the eLMIS were utilized during the TLD transition to identify a rapid distribution plan and stock availability. The data are also being utilized for the pediatric regimen transition. Integration of this system with other systems like Epicor 9 at the MSD has improved delivery times to health facilities.

In FY21, PEPFAR/T will continue to support these systems and data improvements in the supply chain, as well as support other vital areas to commodity security. Activities will include the implementation of the laboratory network optimization recommendations, equipment standardization, and equipment module in eLMIS in order to improve availability of viral load reagents; continued support to the supply chain system redesign roll out; data quality improvements and upgrades to eLMIS; supporting GoT in consistent and agile supply plan monitoring; and support strengthening the quantification of new or scaled up products as they are integrated into the system (i.e. PrEP and self-test kits).

Table 5.7: System barriers related to commodities and supply chain logistics

5.8 Surveillance, Research, and Evaluation (SRE)

Epidemic Control Barrier	Current status (value from Investment to date) (2019 Results)	Key selected activities and benchmarks (2020 Plans)
Inefficient systems and resources for import, product registration, clearance, and distribution of commodities under new policy mandates	Support provided to NACP and MSD to pre-position stock for TLD transition and plan for pediatric optimization. New program products, such as self-test kits, quantified at a national level and registered with regulatory authority.	<p>Activities Support NACP and MSD to support new product demand as a result of pediatric transition and prevention programs.</p> <p>Build capacity of Tanzania Medicines and Medical Devices Authority on medicines evaluation and registration, formulation development, and stability testing.</p> <p>Benchmarks Proportion of eligible pediatric patients transitioned optimized regimens</p> <p>Number of days for product registration and import</p>
Inadequate linkage between patient-level facility data and logistics information system for effective management of ARVs and other commodities	eLMIS Integrated with DHIS2, MSD ERP, and GOTHOMIS-EMR with minimal loading in Health Information Mediator (HIM)	<p>Activities Conduct analysis utilizing supply chain data and clinical data to monitor key program transitions (pediatric transition, Prep, self-testing, etc.). Use data-driven approach for decision making. Support continued roll out of supply chain system redesign. Incorporate new monthly data to ensure agile and responsive national supply chain</p> <p>Benchmarks Facility stock data captured at national level</p>

In COP20, PEPFAR/T is proposing a total of three SREs - surveillance (1), research (1), and evaluation (1). DOD proposes implementing two SREs, one evaluation and one research. CDC proposes implementing three surveillance activities. USAID is not proposing any SRE activities. proposes none.

DOD will continue to implement one evaluation, *The African Cohort Evaluation Study (AFRICOS)*, which aims to longitudinally assess the impact of clinical practices, biological factors, and socio-behavioral issues on HIV-1 infection and disease progression in an African context. Per COP20, sustaining the gains in treatment services is important as along with improving management of HIV advanced disease. This longitudinal assessment will help to understand the impact of long-term co-morbidities on HIV outcomes. DOD will also conduct one research project on *Prevalence of, and factors associated with, virologic suppression and drug resistance in HIV-positive children and adolescents on antiretroviral therapy in Tanzania*. This study will determine the prevalence of viral load suppression and examine factors associated with incomplete viral suppression through HIV drug-resistance testing. Viral suppression in

adolescents is an area that continues to pose challenges towards attaining HIV epidemic control in the Tanzania, thus, understanding facilitators and inhibitors to suppression is a key component of reaching epidemic control. The study will be used to address systematic contributing factors to virologic failure in these age groups through targeted interventions. The data will provide important information for optimizing care models across different age groups to increase engagement in care, retention, adherence, and viral load suppression, which are important in attaining HIV epidemic control.

CDC proposes three surveillance activities for COP20. This includes completion of the *Bio-behavioral survey and size estimation among FSW, MSM, and PWID in mainland Tanzania (IBBS)*; *Establishing Recent Infection Surveillance Using Point of Care Regency Testing among Persons Newly Diagnosed with HIV Infection in Tanzania (HIV recency surveillance)*; and *Tanzania HIV Impact Survey (THIS) A Population-Based HIV Impact Assessment 2020-2021 (PHIA 2020-2021)*.

The *Bio-behavioral survey and size estimation among FSW, MSM, and PWID in mainland Tanzania (IBBS)* is designed to determine size estimates, HIV burden, and identify behavioral risk factors that contribute to HIV infection among key and vulnerable populations. This is in alignment with the COP20 planning letter to prioritize expansion of Key Populations prevention activities. Data from this activity will improve and update Tanzania's data on KP, which is outdated. Currently, the GoT is using size estimations and HIV prevalence of key populations that were generated in 2012; further, the methodology used is not in line with the UNAIDS/WHO KP bio-behavioral guidelines for generation of population size estimates. The data will contribute to improve targeting to reach key populations and ensure enough programming per the number and HIV prevalence of KPs in the country.

The *Establishing Recent Infection Surveillance Using Point of Care Regency Testing among Persons Newly Diagnosed with HIV Infection in Tanzania (HIV recency surveillance)*: is being implemented among persons newly diagnosed with HIV infection by integrating a point of care testing for recent infection into routine HIV testing services with data collection, analysis, and use to support targeted interventions as part of routing program monitoring. A point of care test for recent infection will be applied to blood samples from persons who are identified as newly diagnosed HIV-positive and are determined eligible for the rapid recent infection testing as part of the HIV testing services provided in facility and community settings. The test result will be used only for surveillance purposes to identify recent HIV infections and population groups with new HIV infections. Routine HIV recency surveillance will be established within existing HIV testing services in Tanzania, which includes index partner testing that is conducted to all newly identified PLHIVs. These data will be used at a regional and national level to inform allocation of HIV prevention resources overall and for age, sex, and risk group sub-populations at a regional and national level.

The *Tanzania HIV Impact Survey (THIS) A Population-Based HIV Impact Assessment 2020-2021 (PHIA 2020-2021)* is critical to inform robust PLHIV estimates to further refine the programmatic strategy to reach 95-95-95. Since the PHIA 2016-2017 results, PEPFAR has implemented targeted programmatic activities focused on identification of PLHIV and geographic shifts to focus on regions with low identification of people living with HIV. Updated survey data, paired with improved performance in program data, will address variability in regional estimates that current inhibit accurate target setting and progress monitoring for the reduction of incidence in country as well as retention in care.

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

PEPFAR/T used staffing tools and had extensive agency-level and interagency discussions to identify needs for new or repurposed staff across the interagency team. An interagency management team reviewed the tools and determined that no significant staffing shifts will be required for COP20. The team determined that the overall funding allocation by budget code and the budget code attribution by FTE are well-aligned.

There are currently 22 vacancies across all agencies: DOD (4), USAID (8), CDC (9), and State (1). Most of these are amid the recruitment process, and it is expected that offers of employment will be extended during the 2020 calendar year. Specifically, DOD is in the process of recruiting an M&E Officer and an HIV Care and Support Officer, both of which are expected to be filled by April 2020. These positions will help advance site-level monitoring activities and increase focus on client-centered services respectively. Hiring of an Administrative Assistant will also be finalized this year. Rather than hiring a Deputy Country Director, DOD will hire an eligible family member (EFM) Health Management Communications Officer, which should be filled by July 2020. This was altered due to the skillset needed, lower costs, and faster turnaround time. No new/additional positions will be added during COP20.

CDC is in the process of filling nine vacant positions. Seven of the positions are currently in the recruitment process, and CDC anticipates filling them in May of 2020. Two positions (HIV Treatment Program Officer and HIV Care and Support Public Health Specialist) have taken over a year to process due to long turnaround for position classification. CDC is working with the Embassy to get these positions filled as soon as possible. The position of PEPFAR Coordinator which shifted from State to CDC will be filled in mid-2020, which leaves a vacancy in State for the Deputy PEPFAR Coordinator position. This position will be filled through USAID's PSC mechanism, and recruitment has started.

CDC will add two positions for COP20, a Health Policy Analyst (HPA) and a Public Health Advisor (PHA). Both positions currently reside within CDC's Division of Global Health Protection. The principal role of the HPA (local hire) is to promote and provide understanding of the U.S. Government's initiative to fight HIV and AIDS and other CDC programs in Tanzania. In furtherance, the HPA will manage the design, implementation, and coordination of all CDC policy and communications activities. The PHA is a direct hire and its role is cross-cutting of both GHSA and PEPFAR activities. This PHA will assist CDC with the translation of data results to ensure internal and external stakeholders' understanding of program implementation and priorities.

USAID's staffing structure will remain the same, which puts USAID in a good position to achieve program goals and 95-95-95 targets. They are in the process of filling eight vacant positions. For three of these vacancies, offers have been made, and start dates set for March 2020. For two of the vacant positions, offers have been made and start dates will be set pending medical and security clearances. The remaining vacancies are awaiting final approval from USAID HQ and classification.

State is currently recruiting for one additional locally employed staff (LES) position of Grant Officer Representative, which is new to its staffing pattern in response to the need for more regular site visits and monitoring of small grant recipients. These site visits will be amplified by

the addition of community-led monitoring to the PEPFAR Small Grant portfolio. State is also recruiting an EFM for the anticipated departure of the incumbent Grant Officer.

Peace Corps is maintaining the same staffing positions for COP20 as it had in COP19. No missing skills or competencies have been identified, and thus no changes in staffing are needed to achieve program priorities. During FY20, Peace Corps encountered challenges in obtaining work permits for the group of 40 first-year Health and Agriculture Volunteers supported by PEPFAR. Thus, this group was unable to stay and complete two years of service in Tanzania. Simultaneously, Peace Corps was also obliged to cancel the incoming class of 40 additional PEPFAR-funded Volunteers. These events will reduce our overall PEPFAR achievements during FY20 and are likewise expected to reduce achievements in the upcoming FY21 since volunteers serve for a period of two years. In addition, due to a COVID19 pandemic precautions, Peace Corps is evacuating all remaining volunteers from Tanzania. This is a temporary suspension of activities. When conditions permit, Peace Corps will resume operations. In FY21, to ensure that Peace Corps continues to contribute towards achievements in HIV prevention, PEPFAR/T will plan to assign about 35% of Secondary Education Volunteers (potentially 15) to PEPFAR. These Volunteers will be trained to conduct after-school secondary activities to support our efforts in reaching AGYW. This will serve to mitigate the overall reduction of activities due to the reduced numbers of Volunteers serving in the country. Peace Corps non-PEPFAR funded Secondary Education Volunteers working in schools all over the country will also continue to reach AGYW and support PEPFAR achievements in HIV Prevention. Peace Corps is actively working with the GoT to clarify new procedures related to Volunteer qualifications, recruitment, and placement for Tanzania to get back on track with a new class of potentially 40 PEPFAR-funded volunteers in Q2 of FY21.

Note that with the above minor changes, staffing across PEPFAR/T is adequate to meet SIMS requirements, as well as addressing the large identified programmatic and data gaps.

Each implementing agency in PEPFAR/T conducted an internal staffing review to ensure that staff time is aligned with core programmatic, population, and geographic priorities, as well as business process coverage. Agencies continuously assess the most important needs when vacancies occur and repurpose appropriately. USAID's cost of doing business (CODB) will increase by 1%. DOD's and Peace Corps' CODB remains the same from the previous year. CDC anticipates an increase in their CODB as they absorb the full cost of the PEPFAR Coordinator position, but this is offset by a corresponding reduction in State's CODB.

PEPFAR/T is in the process of revising its interagency team structure to be focused on changing priorities since the original structure was established in 2015. The structure has put in place working groups that are goal oriented, rather than technical area focused. For example, there is a group focused on ending mother to child transmission, a group focused on identifying, linking, and retaining patients, and a group focused on reducing mortality, to name a few. These Goal Teams will be focused on four action pillars: (1) generate data to drive performance, (2) ensure all sites are performing, (3) ensure implementation of effective policies, and (4) developing activities and tools to support effective implementation and CQI. The Goal Teams will develop 30-60-90 day plans to address these action pillars and will report on their progress at weekly PEPFAR Steering Committee meetings. Cross-cutting Core Groups will also be established focused on HIS/data systems, supply chain and commodities, HRH and health financing, and reporting. These Core Groups will provide support to the Goal Teams to ensure they achieve their objectives. This new structure will be Beta tested starting in FY19 Q2/Q3 and refined based on experience.

APPENDIX A -- PRIORITIZATION

Table A.1: PSNU Prioritization and ART Coverage

Region	PSNU	Prioritization	All	All	All	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
			Total	<15	15+	<01	<01	01-04	01-04	05-09	05-09	10-14	10-14	15-19	15-19	20-24	20-24	25-29	25-29	30-34	30-34	35-39	35-39	40-44	40-44	45-49	45-49	50+
Military Tanzania	Military Tanzania	Scale-up: Saturation	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
Arusha	Arusha CC	Scale-up: Saturation	125%	124%	125%	120%	122%	124%	126%	124%	125%	124%	124%	125%	125%	125%	125%	125%	125%	125%	125%	125%	125%	125%	125%	125%	125%	125%
Arusha	Arusha DC	Scale-up: Saturation	117%	118%	117%	133%	100%	117%	118%	119%	115%	118%	119%	117%	117%	117%	117%	117%	117%	117%	117%	117%	117%	117%	117%	117%	117%	117%
Manyara	Babati DC	Sustained	99%	99%	99%	100%	100%	100%	100%	100%	100%	97%	97%	98%	99%	99%	99%	99%	99%	99%	98%	99%	98%	98%	99%	99%	98%	99%
Manyara	Babati TC	Sustained	112%	112%	112%	100%	100%	113%	113%	111%	111%	114%	114%	113%	111%	111%	112%	111%	112%	112%	112%	112%	112%	112%	112%	112%	112%	112%
Pwani	Bagamoyo DC	Sustained	80%	81%	80%	75%	87%	81%	81%	82%	81%	82%	81%	81%	80%	81%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Dodoma	Bahi DC	Sustained	63%	63%	63%	67%	67%	62%	67%	65%	63%	63%	62%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%	63%
Simiyu	Bariadi DC	Sustained	42%	42%	42%	33%	40%	42%	40%	42%	42%	41%	42%	42%	41%	42%	42%	41%	42%	42%	42%	42%	42%	42%	42%	42%	42%	42%
Simiyu	Bariadi TC	Sustained	103%	103%	103%	100%	100%	104%	104%	103%	103%	103%	103%	103%	103%	103%	104%	104%	103%	104%	103%	103%	104%	103%	103%	103%	103%	103%
Kagera	Biharamulo DC	Scale-up: Saturation	81%	81%	81%	78%	78%	81%	83%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%	81%
Mwanza	Buchosa DC	Scale-up: Saturation	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%
Kigoma	Buhigwe DC	Sustained	36%	35%	37%	0%	0%	33%	33%	39%	35%	35%	37%	35%	37%	36%	37%	37%	36%	36%	37%	36%	37%	37%	36%	37%	37%	36%
Kagera	Bukoba DC	Scale-up: Saturation	82%	82%	82%	81%	81%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%	82%
Kagera	Bukoba MC	Attained	84%	83%	84%	82%	80%	84%	83%	84%	83%	84%	83%	84%	83%	84%	84%	83%	84%	83%	84%	84%	83%	84%	84%	83%	84%	84%
Geita	Bukombe DC	Scale-up: Saturation	90%	90%	90%	90%	90%	89%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Tanga	Bumbuli DC	Sustained	67%	67%	67%	100%	100%	60%	75%	67%	64%	65%	69%	67%	66%	67%	67%	66%	67%	66%	67%	67%	67%	67%	67%	67%	67%	67%
Mara	Bunda DC	Scale-up: Saturation	91%	91%	91%	100%	100%	90%	90%	91%	91%	92%	92%	91%	92%	92%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%
Mara	Bunda TC	Sustained	103%	102%	103%	100%	100%	105%	100%	102%	102%	103%	102%	102%	102%	102%	102%	103%	103%	103%	103%	103%	103%	102%	103%	103%	103%	103%
Simiyu	Busega DC	Scale-up: Saturation	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Mbeya	Busokelo DC	Sustained	89%	89%	89%	80%	80%	88%	87%	90%	89%	89%	88%	89%	89%	89%	89%	89%	89%	89%	89%	89%	89%	89%	89%	89%	89%	89%
Mara	Butama DC	Sustained	47%	48%	47%	50%	50%	50%	47%	48%	48%	47%	47%	48%	47%	47%	48%	47%	47%	47%	47%	47%	47%	47%	47%	47%	47%	47%
Kusini Pemba	Chake	Sustained	120%	122%	120%	0%	0%	100%	100%	125%	125%	125%	125%	117%	125%	114%	120%	120%	119%	123%	121%	120%	122%	122%	120%	118%	119%	121%

Peani	Chalizo DC	Scale-up: Saturation	102 %	101 %	102 %	100 %	100 %	100 %	100 %	102 %	102 %	102 %	102 %	102 %	102 %	102 %	102 %	102 %	102 %	102 %	102 %	102 %	102 %	102 %	102 %	102 %	102 %
Dodoma	Chamwino DC	Sustained	97%	98%	97%	100 %	100 %	100 %	100 %	97%	97%	97%	97%	97%	98%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%
Geita	Chato DC	Scale-up: Saturation	91%	91%	91%	88%	88%	91%	90%	91%	91%	91%	91%	90%	90%	91%	90%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%
Dodoma	Chemba DC	Sustained	47%	48%	47%	0%	0%	50%	50%	48%	50%	48%	50%	50%	48%	48%	48%	47%	47%	47%	48%	48%	48%	48%	47%	47%	47%
Mboya	Chanya DC	Sustained	108 %	108 %	108 %	100 %	100 %	105 %	105 %	108 %	108 %	108 %	108 %	108 %	108 %	108 %	108 %	108 %	108 %	108 %	108 %	108 %	108 %	108 %	108 %	108 %	108 %
Dodoma	Dodoma MC	Attained	112 %	112 %	112 %	109 %	110 %	112 %	113 %	112 %	111 %	112 %	112 %	112 %	112 %	112 %	112 %	112 %	112 %	112 %	112 %	112 %	112 %	112 %	112 %	112 %	112 %
Morogoro	Gairo DC	Scale-up: Saturation	98%	100 %	98%	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	97%	98%	97%	99%	98%	98%	99%	98%	98%	98%	98%	98%	98%	98%
Geita	Geita DC	Scale-up: Saturation	91%	91%	91%	93%	93%	92%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%
Geita	Geita TC	Scale-up: Saturation	90%	90%	90%	89%	89%	91%	90%	90%	90%	90%	90%	90%	91%	90%	91%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Kilimanjaro	Hai DC	Sustained	72%	71%	72%	67%	67%	71%	69%	72%	71%	71%	73%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%
Manyara	Hanang DC	Sustained	74%	73%	74%	50%	50%	79%	71%	79%	72%	74%	76%	74%	79%	74%	74%	74%	74%	74%	74%	74%	74%	74%	74%	74%	74%
Tanga	Handeni DC	Sustained	51%	51%	51%	50%	50%	53%	50%	51%	50%	51%	50%	51%	51%	50%	51%	51%	51%	51%	51%	51%	51%	51%	51%	51%	51%
Tanga	Handeni TC	Sustained	61%	60%	61%	50%	50%	60%	58%	63%	61%	61%	60%	61%	61%	61%	61%	61%	61%	61%	61%	61%	61%	61%	61%	61%	61%
Morogoro	Ilakaa TC	Sustained	133 %	134 %	133 %	133 %	133 %	133 %	133 %	133 %	135 %	133 %	133 %	133 %	132 %	133 %	133 %	133 %	133 %	133 %	133 %	133 %	133 %	133 %	133 %	133 %	133 %
Tabora	Igunga DC	Scale-up: Saturation	91%	91%	91%	93%	93%	91%	90%	90%	91%	91%	91%	90%	90%	90%	90%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%
Singida	Ikungi DC	Sustained	78%	77%	78%	100 %	100 %	80%	80%	77%	78%	79%	77%	78%	78%	78%	78%	78%	78%	79%	78%	78%	78%	79%	78%	78%	78%
Dar es Salaam	Ila MC	Scale-up: Saturation	99%	99%	99%	98%	100 %	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
Songwe	Ileje DC	Scale-up: Saturation	93%	93%	93%	100 %	100 %	90%	90%	93%	93%	94%	96%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Mwanza	Ilemela MC	Attained	88%	88%	88%	91%	91%	88%	88%	88%	88%	88%	89%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%
Singida	Iimba DC	Scale-up: Saturation	104 %	104 %	104 %	100 %	100 %	106 %	107 %	105 %	103 %	104 %	104 %	104 %	104 %	104 %	104 %	104 %	104 %	104 %	104 %	104 %	104 %	104 %	104 %	104 %	104 %
Iringa	Iringa DC	Scale-up: Saturation	96%	96%	96%	92%	100 %	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%
Iringa	Iringa MC	Attained	117 %	117 %	117 %	120 %	122 %	117 %	116 %	117 %	117 %	117 %	117 %	117 %	117 %	117 %	117 %	117 %	117 %	117 %	117 %	117 %	117 %	117 %	117 %	117 %	117 %
Singida	Iligi DC	Sustained	123 %	123 %	123 %	100 %	100 %	122 %	125 %	124 %	124 %	123 %	124 %	123 %	123 %	123 %	123 %	123 %	123 %	123 %	123 %	123 %	123 %	123 %	123 %	123 %	123 %
Simiyu	Ilima DC	Scale-up: Saturation	97%	97%	97%	100 %	100 %	96%	96%	97%	97%	97%	97%	98%	97%	98%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%
Shinyanga	Kahama TC	Attained	90%	90%	90%	92%	92%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Kigoma	Kakonko DC	Sustained	58%	58%	58%	50%	50%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%	58%
Rukwa	Kalambo DC	Scale-up: Saturation	99%	98%	99%	100 %	100 %	100 %	100 %	98%	97%	98%	98%	98%	99%	98%	99%	99%	99%	99%	99%	98%	98%	99%	99%	98%	99%
Tabora	Kalisa DC	Scale-up: Saturation	91%	91%	91%	92%	91%	91%	90%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%
Kigoma	Kanigwe DC	Scale-up: Saturation	79%	79%	79%	73%	73%	79%	74%	79%	79%	79%	79%	79%	79%	79%	79%	79%	79%	79%	79%	79%	79%	79%	79%	79%	79%
Arusha	Karatu DC	Sustained	71%	70%	71%	50%	50%	70%	67%	70%	73%	72%	70%	70%	71%	70%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%	71%
Kaokazi Lingya	Kaokazi A	Sustained	114 %	100 %	115 %	0%	0%	100 %	100 %	100 %	100 %	100 %	100 %	125 %	117 %	120 %	117 %	111 %	117 %	115 %	113 %	113 %	115 %	117 %	116 %	114 %	114 %
Kaokazi Lingya	Kaokazi B	Sustained	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Kigoma	Kasulu DC	Sustained	52%	52%	52%	67%	50%	50%	50%	51%	53%	53%	51%	51%	52%	51%	51%	51%	52%	52%	51%	51%	51%	51%	52%	52%	52%

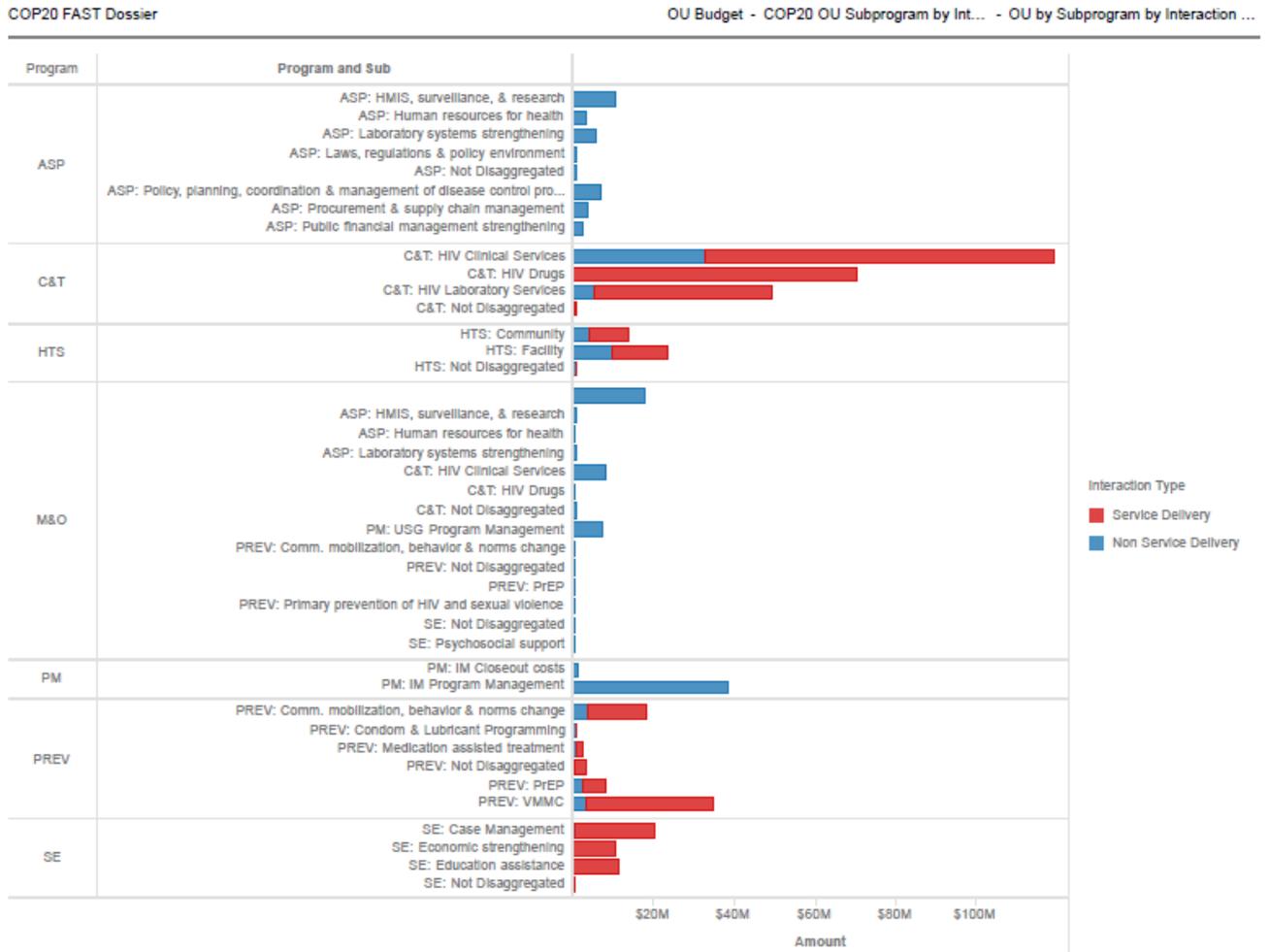
Raruma	Madaba DC	Sustained	84%	84%	84%	100%	100%	80%	89%	88%	88%	83%	83%	84%	83%	83%	83%	83%	83%	84%	83%	84%	84%	84%	84%	84%	84%
Pwani	Mafia DC	Sustained	49%	46%	49%	0%	0%	40%	40%	50%	50%	50%	50%	48%	48%	48%	49%	48%	49%	49%	48%	49%	49%	48%	49%	49%	
Iringa	Mafinga TC	Scale-up: Saturation	96%	96%	96%	100%	100%	94%	97%	98%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%
Mjini Magharibi	Magharibi A	Sustained	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
Mjini Magharibi	Magharibi B	Scale-up: Saturation	257%	260%	257%	300%	300%	250%	267%	263%	257%	256%	256%	254%	255%	259%	258%	257%	257%	256%	256%	257%	257%	256%	256%	257%	257%
Mwanza	Maga DC	Scale-up: Saturation	89%	89%	89%	89%	88%	89%	89%	89%	89%	89%	89%	89%	89%	89%	89%	89%	89%	89%	89%	89%	89%	89%	89%	89%	89%
Njombe	Makambako TC	Scale-up: Saturation	106%	106%	106%	111%	111%	107%	105%	106%	106%	106%	106%	106%	106%	106%	106%	106%	106%	106%	106%	106%	106%	106%	106%	106%	106%
Njombe	Makoto DC	Scale-up: Saturation	94%	94%	94%	100%	100%	94%	94%	96%	94%	94%	94%	96%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%
Morogoro	Malinyi DC	Sustained	91%	91%	91%	100%	100%	90%	90%	92%	92%	89%	89%	90%	91%	90%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%
Singida	Manyoni DC	Sustained	85%	85%	85%	100%	100%	87%	87%	84%	84%	85%	84%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Mwara	Masasi DC	Scale-up: Saturation	108%	108%	108%	114%	114%	109%	107%	108%	108%	108%	108%	108%	108%	108%	108%	108%	108%	108%	108%	108%	108%	108%	108%	108%	108%
Mwara	Masasi TC	Sustained	106%	106%	106%	100%	100%	107%	106%	107%	104%	106%	106%	105%	106%	105%	106%	106%	105%	105%	106%	106%	106%	106%	106%	106%	106%
Simiyu	Maswa DC	Scale-up: Saturation	112%	112%	112%	116%	116%	112%	112%	112%	112%	112%	112%	112%	112%	112%	112%	112%	112%	112%	112%	112%	112%	112%	112%	112%	112%
Mbeya	Mbarali DC	Scale-up: Saturation	93%	93%	93%	92%	92%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Mbeya	Mbeya CC	Attained	92%	92%	92%	93%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
Mbeya	Mbeya DC	Scale-up: Saturation	97%	97%	97%	94%	94%	96%	96%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%
Raruma	Mbinga DC	Scale-up: Saturation	98%	97%	98%	100%	100%	96%	96%	97%	97%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
Raruma	Mbinga TC	Scale-up: Saturation	103%	103%	103%	100%	100%	104%	104%	103%	103%	103%	102%	103%	103%	103%	103%	103%	103%	103%	103%	103%	103%	103%	103%	103%	103%
Geita	Mbogwe DC	Scale-up: Saturation	90%	90%	90%	89%	89%	91%	90%	90%	90%	91%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Songwe	Mbozi DC	Scale-up: Saturation	92%	92%	92%	94%	94%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
Manyara	Mbulu DC	Sustained	104%	106%	104%	100%	100%	100%	100%	108%	108%	108%	107%	105%	103%	104%	104%	105%	104%	104%	104%	104%	104%	105%	105%	104%	105%
Manyara	Mbulu TC	Sustained	111%	112%	111%	100%	0%	100%	100%	117%	117%	113%	113%	108%	113%	114%	112%	110%	112%	110%	111%	111%	110%	112%	111%	111%	111%
Simiyu	Mwasi DC	Scale-up: Saturation	108%	108%	108%	111%	111%	107%	108%	108%	108%	107%	108%	108%	108%	108%	107%	108%	108%	108%	108%	108%	108%	108%	108%	108%	108%
Anziba	Mtisi DC	Sustained	62%	62%	62%	60%	60%	64%	62%	62%	63%	62%	62%	62%	62%	63%	63%	62%	62%	62%	62%	62%	63%	63%	62%	63%	62%
Kaskazini Pemba	Micheweni	Sustained	144%	100%	146%	0%	0%	0%	0%	100%	100%	100%	100%	150%	150%	150%	150%	133%	150%	150%	143%	150%	150%	140%	143%	140%	146%
Kagera	Misisyeri DC	Scale-up: Saturation	120%	120%	120%	122%	125%	120%	121%	120%	120%	120%	119%	120%	120%	120%	120%	120%	120%	120%	120%	120%	120%	120%	120%	120%	120%
Mwanza	Misungwi DC	Scale-up: Saturation	89%	88%	89%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%
Mjini Magharibi	Mjini	Scale-up: Saturation	106%	107%	106%	100%	100%	108%	108%	108%	108%	107%	107%	106%	106%	106%	106%	106%	106%	106%	106%	106%	106%	106%	106%	106%	106%
Singida	Mtalama DC	Sustained	99%	100%	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%	100%	99%	100%	99%	100%	99%	100%	99%	99%	
Tanga	Mkinga DC	Sustained	91%	90%	91%	100%	100%	88%	88%	89%	88%	91%	91%	92%	91%	90%	90%	91%	91%	91%	91%	91%	90%	91%	91%	91%	91%
Kuini Pemba	Mkoani	Sustained	100%	100%	100%	0%	0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Pwani	Mkuranga DC	Scale-up: Saturation	103%	103%	103%	100%	100%	105%	105%	104%	102%	103%	104%	103%	103%	103%	103%	103%	103%	103%	103%	103%	103%	103%	103%	103%	103%
Kilifi	Mlele DC	Sustained	118%	117%	118%	100%	100%	122%	113%	117%	117%	120%	117%	119%	120%	117%	118%	119%	118%	118%	119%	118%	118%	119%	118%	118%	118%

Osaka		Sustained	58%	58%	58%	60%	60%	57%	59%	58%	57%	58%	58%	58%	58%	57%	58%	58%	58%	57%	58%	57%	58%	58%	58%	57%	58%	57%	
Ruvuma	Nyasa DC	Sustained	89%	89%	89%	100%	100%	88%	88%	89%	89%	88%	89%	88%	89%	89%	88%	89%	88%	89%	88%	89%	88%	89%	88%	89%	88%	89%	
Tabona		Scale-up: Saturation	91%	91%	91%	91%	91%	92%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%		
Tabona		Sustained	65%	65%	65%	67%	67%	62%	62%	66%	65%	65%	65%	64%	64%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	
Tanga		Sustained	103%	100%	103%	100%	100%	100%	100%	100%	100%	100%	104%	103%	103%	103%	104%	103%	104%	103%	103%	103%	103%	103%	103%	103%	103%	103%	
Kilimanjaro	Rombo DC	Sustained	72%	71%	72%	67%	67%	66%	73%	72%	71%	72%	71%	72%	72%	71%	72%	72%	71%	72%	72%	72%	72%	72%	72%	72%	72%	72%	
Masa	Ronya DC	Scale-up: Saturation	91%	91%	91%	94%	93%	91%	92%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	
Lindi		Sustained	97%	98%	97%	100%	100%	100%	100%	97%	97%	97%	97%	97%	97%	98%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	97%	
Pwani	Rufiji DC	Sustained	99%	100%	99%	100%	100%	100%	100%	100%	100%	100%	100%	98%	98%	98%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	
Mbeya	Rungwe DC	Scale-up: Saturation	91%	91%	91%	89%	89%	91%	90%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	
Kilimanjaro	Semo DC	Sustained	57%	56%	57%	50%	60%	56%	56%	57%	56%	56%	57%	57%	57%	56%	57%	57%	57%	56%	57%	57%	57%	57%	57%	57%	57%	57%	
Mwanza		Scale-up: Saturation	91%	90%	91%	91%	91%	90%	90%	90%	91%	90%	91%	91%	91%	91%	91%	91%	90%	91%	91%	91%	91%	91%	91%	91%	91%	91%	
Masa	Serengeti DC	Scale-up: Saturation	91%	91%	91%	100%	100%	88%	88%	91%	90%	91%	91%	90%	91%	90%	90%	90%	91%	91%	91%	90%	91%	90%	90%	90%	90%	91%	
Shinyanga	Shinyanga DC	Scale-up: Saturation	83%	83%	83%	83%	83%	82%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	83%	
Shinyanga	Shinyanga MC	Scale-up: Saturation	114%	114%	114%	117%	117%	115%	115%	114%	115%	114%	114%	114%	114%	114%	114%	114%	114%	114%	114%	114%	114%	114%	114%	114%	114%	114%	
Kilimanjaro	Sha DC	Sustained	80%	80%	80%	87%	100%	83%	82%	79%	79%	81%	81%	80%	79%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	
Tabona		Sustained	113%	113%	113%	125%	125%	111%	111%	114%	113%	113%	113%	114%	113%	113%	113%	113%	113%	113%	113%	113%	113%	113%	113%	113%	113%	113%	
Manyara		Sustained	84%	85%	84%	100%	100%	86%	86%	82%	85%	84%	84%	83%	84%	84%	84%	83%	83%	84%	83%	84%	84%	83%	83%	84%	84%	84%	
Singida	Singida DC	Sustained	72%	73%	72%	100%	100%	75%	75%	70%	70%	69%	75%	70%	71%	74%	71%	72%	72%	73%	72%	72%	72%	71%	72%	72%	71%	71%	72%
Singida	Singida MC	Sustained	119%	119%	119%	133%	133%	115%	117%	117%	117%	120%	119%	118%	119%	119%	119%	119%	119%	119%	119%	118%	119%	119%	119%	119%	118%	119%	
Ruvuma		Scale-up: Saturation	101%	101%	101%	100%	100%	100%	100%	100%	100%	102%	102%	101%	101%	101%	101%	102%	101%	101%	101%	101%	101%	101%	101%	101%	101%	101%	
Ruvuma		Attained	95%	95%	95%	100%	100%	95%	95%	94%	94%	95%	95%	95%	94%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	
Songwe	Songwe DC	Scale-up: Saturation	98%	98%	98%	100%	100%	97%	97%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	
Rukwa	Sumbawanga DC	Scale-up: Saturation	92%	92%	92%	89%	89%	93%	93%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	
Rukwa	Sumbawanga MC	Scale-up: Saturation	93%	93%	93%	88%	88%	92%	94%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	
Tabona	Tabona MC	Attained	91%	90%	91%	86%	83%	90%	90%	91%	91%	90%	90%	90%	90%	91%	91%	90%	91%	91%	91%	91%	91%	91%	91%	91%	91%	91%	
Mwara	Tandimba DC	Sustained	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Tanga	Tanga DC	Scale-up: Saturation	115%	114%	115%	111%	111%	114%	115%	114%	115%	115%	114%	115%	115%	115%	115%	115%	115%	115%	115%	115%	115%	115%	115%	115%	115%	115%	
Masa	Tarimo DC	Sustained	72%	72%	72%	67%	67%	71%	69%	73%	72%	73%	72%	71%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	72%	
Masa	Tarimo TC	Scale-up: Saturation	95%	97%	95%	100%	100%	100%	100%	98%	98%	98%	98%	95%	96%	94%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	
Dar es Salaam	Temeke MC	Scale-up: Saturation	87%	87%	87%	87%	86%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	
Songwe		Scale-up: Saturation	93%	93%	93%	100%	100%	93%	93%	94%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	
Ruvuma	Tunduru DC	Scale-up: Saturation	102%	102%	103%	100%	100%	105%	100%	102%	102%	103%	103%	102%	103%	103%	103%	102%	103%	102%	102%	102%	103%	103%	103%	103%	103%	103%	

APPENDIX B – Budget Profile and Resource Projections

B1. COP20 Planned Spending in alignment with planning level letter guidance

Table B.1.1: COP20 Budget by Program Area



Applied Pipeline	New Funding	Total Spend
\$69,855,930	\$426,743,007	\$496,598,937

*Data included in Table B.1.2 should match FACTS Info records and total applied pipeline amount required in PLL guidance.

Table B.1.3: Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	\$3,757,147
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	\$194,039
HVOP	Other Sexual Prevention	\$25,357,856
IDUP	Injecting and Non-Injecting Drug Use	\$2,623,103
HMBL	Blood Safety	\$0
HMIN	Injection Safety	\$0
CIRC	Male Circumcision	\$26,748,177
HVCT	Counseling and Testing	\$39,511,950
HBHC	Adult Care and Support	\$11,793,808
PDCS	Pediatric Care and Support	\$21,406,539
HKID	Orphans and Vulnerable Children	\$26,822,848
HTXS	Adult Treatment	\$145,995,452
HTXD	ARV Drugs	\$54,139,102
PDTX	Pediatric Treatment	\$16,646,121
HVTB	TB/HIV Care	\$7,536,668
HLAB	Lab	\$11,907,925
HVSI	Strategic Information	\$7,255,231
OHSS	Health Systems Strengthening	\$7,718,513
HVMS	Management and Operations	\$17,328,528
TOTAL		\$426,743,007

B.2 Resource Projections

Primary input to budgeting process was recent PLHIV and coverage estimates from Tanzania PHIA (THIS) and updated projections from Spectrum. Adjustments were made to existing agency and mechanism level allocations according to shifts in HIV treatment gap.

In addition, agencies and program officers consulted with expenditure analysis data, work plans, performance reports and S/APR data. Additional consideration was given to earmarks and expected cross-cutting attributions based on the Planning Level Ceiling.

For above site investments, progress against expected milestones or outcomes was reviewed and budgets adjusted accordingly in relation to completed activities. New initiatives or system needs were reviewed in relation to gaps, barriers that directly impact capacity of program to achieve epidemic control or SID scores.

APPEIDIX C – Tables and Systems Investments for Section 6.0

Table 6.0: Inventory of Above-Bill Programs (Continued)									
Funding Agency	Prime Partner	COP20 Program Area	COP20 Beneficiary	COP20 Activity Category	Key Systems Barrier	Intervention Start	Intervention Interval	COP20 Benchmark	
USAID	Chemonics International, Inc.	ASP: Not Disaggregated-NSD	Non-Targeted Pop: Not disaggregated	Lab policy, budgets, and	Inadequate linkage between patient-level facility data and logistics information system for effective management of ARVs and commodities	COP20	COP21	HRH inventory completed	
USAID	Unicef	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	Inefficient system for HCWs prioritization, recruitment, production, allocation, and retention across priority service delivery sites	COP20	COP20	100	
USAID	Unicef	ASP: Laws, regulations & policy environment-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	Gaps in surveillance and program data (i.e. data quality and completeness, HI systems) impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels and improve patient-level service delivery and monitoring	COP17	COP20	95%	
USAID	Unicef	ASP: Policy, planning, coordination & management-NSD	Females: Young women & adolescent females	Training in coordination and management of health systems	Slow adoption and implementation of key evidence based policies, guidelines and procedures to facilitate rapid scale up and implementation with fidelity of ART optimization, Viral Load/Early Infant Diagnosis (EID) optimization, HIV self-testing, PEP, TB Preventive Therapy (TPT), Differentiated Care Service Delivery Models (DSDM), Multi Month Dispensing (MMD), use of lay workers, biometric unique identifier and other key strategies across scale up councils and key populations.	COP18	COP20	90%	
USAID	T-MARC TANZANIA	ASP: Not Disaggregated-NSD	Non-Targeted Pop: Not disaggregated	Market opens	Lack of strategic engagement of faith based and private sector for achieving epidemic control and shortage of market segmentation/total market approach	COP19	COP20	4	
HHS/CDC	Management Sciences For Health, Inc.	ASP: HMS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMS systems	Gaps in surveillance and program data (i.e. data quality and completeness, HI systems) impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels and improve patient-level service delivery and monitoring	COP18	COP22	a) 97% of CTC client data in CTC3SHR b) 60% of C&T clients records linked NHCR c) 50% of HTS_TST_POS in CTC3SHR d) 40% of HTS-client records linked to NHCR e) 60% of C&T client records have Biometric ID	
HHS/CDC	Management Sciences For Health, Inc.	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	Inadequate number of competent HRH to deliver quality team-based care services for differentiated service delivery modalities in facility and community sites	COP16	COP20	A reduction in vacancy rate to 40% (all cadres)	
HHS/CDC	Management Sciences For Health, Inc.	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Service organization and management systems	Slow adoption and implementation of key evidence based policies, guidelines and procedures to facilitate rapid scale up and implementation with fidelity of ART optimization, Viral Load/Early Infant Diagnosis (EID) optimization, HIV self-testing, PEP, TB Preventive Therapy (TPT), Differentiated Care Service Delivery Models (DSDM), Multi Month Dispensing (MMD), use of lay workers, biometric unique identifier and other key strategies across scale up councils and key populations.	COP18	COP20	Development and revision of guideline/policies by all PHs are informed by qualitative and quantitative data	
HHS/CDC	UNIVERSITY OF MARYLAND	ASP: HMS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	Gaps in surveillance and program data (i.e. data quality and completeness, HI systems) impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels and improve patient-level service delivery and monitoring	COP18	COP21	60 additional high priority facilities installed with ECHO platform and fully functional	
HHS/CDC	UNIVERSITY OF MARYLAND	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and preparation to	Gaps in surveillance and program data (i.e. data quality and completeness, HI systems) impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels and improve patient-level service delivery and monitoring	COP19	COP21	All tier 1 and 2 facilities meet client-centered care minimum standards	
HHS/CDC	Trustees Of Columbia University In The City Of New York	ASP: HMS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	Gaps in surveillance and program data (i.e. data quality and completeness, HI systems) impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels and improve patient-level service delivery and monitoring	COP19	COP22	Complete data collection; hold national consensus meeting to revise estimates on key population size	
HHS/CDC	Trustees Of Columbia University In The City Of New York	ASP: HMS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	Gaps in surveillance and program data (i.e. data quality and completeness, HI systems) impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels and improve patient-level service delivery and monitoring	COP20	COP21	Completion of data collection and preliminary analyses	
HHS/CDC	Trustees Of Columbia University In The City Of New York	ASP: HMS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	Gaps in surveillance and program data (i.e. data quality and completeness, HI systems) impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels and improve patient-level service delivery and monitoring	COP19	COP22	Completion of recency testing in high burden facilities that comprise of 50% of TX_NEW.	
HHS/CDC	UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS	ASP: HMS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	Gaps in surveillance and program data (i.e. data quality and completeness, HI systems) impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels and improve patient-level service delivery and monitoring	COP17	COP20	1) HR estimates developed and annual support for maintenance of regional spectrum files 2) Fast Track Action Plans for cities developed	
USAID	Abt Associates Inc.	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	Institutionalization in-service training	Lack of strategic engagement of faith based and private sector for achieving epidemic control and shortage of market segmentation/total market approach	COP20	COP22	30%	
USAID	Abt Associates Inc.	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	Private sector engagement	Lack of strategic engagement of faith based and private sector for achieving epidemic control and shortage of market segmentation/total market approach	COP20	COP22	5%	
DOD	Henry M. Jackson Foundation For The Advancement Of Military Medicine, Inc., The	ASP: Not Disaggregated-NSD	Non-Targeted Pop: Not disaggregated	Clinical guidelines, policies for service delivery	Slow adoption and implementation of key evidence based policies, guidelines and procedures to facilitate rapid scale up and implementation with fidelity of ART optimization, Viral Load/Early Infant Diagnosis (EID) optimization, HIV self-testing, PEP, TB Preventive Therapy (TPT), Differentiated Care Service Delivery Models (DSDM), Multi Month Dispensing (MMD), use of lay workers, biometric unique identifier and other key strategies across scale up councils and key populations.	COP20	COP20	1) Participants will demonstrate a 25% decrease in perceived discrimination from baseline data. 2) All military sponsored trainings/meetings will incorporate a module on stigma and discrimination reduction	
USAID	Palladium International, LLC	ASP: Laws, regulations & policy environment-NSD	Non-Targeted Pop: Not disaggregated	Domestic resource mobilization	Insufficient public resource commitments and expenditures to meet national HIV program needs for epidemic control	COP20	COP22	5%	
HHS/CDC	OFFICE OF CHIEF MEDICAL OFFICER	ASP: HMS, surveillance, & research-NSD	Key Pops: Not disaggregated	Program and data quality management	Gaps in surveillance and program data (i.e. data quality and completeness, HI systems) impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels and improve patient-level service delivery and monitoring	COP18	COP20	Stakeholder engagement and dissemination of KP population estimates, including HIV and STI prevalence data to improve HTS and inform relevant policy.	
HHS/CDC	OFFICE OF CHIEF MEDICAL OFFICER	ASP: HMS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	Gaps in surveillance and program data (i.e. data quality and completeness, HI systems) impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels and improve patient-level service delivery and monitoring	COP18	COP22	1) 99% of SNUUs report timely (high quality data) recency surveillance and mortality surveillance established countrywide	
HHS/CDC	OFFICE OF CHIEF MEDICAL OFFICER	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	Institutionalization in-service training	Inefficient system for HCWs prioritization, recruitment, production, allocation, and retention across priority service delivery sites	COP17	COP21	25% of high burden sites visited/trained, certified and mentored on task sharing and SDM per the policy & national M&E tools (in collaboration with clinical IP&S and PORALG)	
HHS/CDC	OFFICE OF CHIEF MEDICAL OFFICER	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Inadequate capacity to manage diagnostic network optimization for VL, EID, and TB, supply chain modernization and laboratory quality management including the fidelity of the lab/inform interface	COP17	COP21	At least 50% of testing sites (Lab-POCT) implementing National QI Programs	
HHS/CDC	OFFICE OF CHIEF MEDICAL OFFICER	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Service organization and management systems	Slow adoption and implementation of key evidence based policies, guidelines and procedures to facilitate rapid scale up and implementation with fidelity of ART optimization, Viral Load/Early Infant Diagnosis (EID) optimization, HIV self-testing, PEP, TB Preventive Therapy (TPT), Differentiated Care Service Delivery Models (DSDM), Multi Month Dispensing (MMD), use of lay workers, biometric unique identifier and other key strategies across scale up councils and key populations.	COP18	COP21	1) >80% of SNUUs utilize qualitative and quantitative data to inform policy implementation toward client centered care 2) >80% of facilities with 3 stars and above using revised star rating tools	
HHS/CDC	OFFICE OF CHIEF MEDICAL OFFICER	ASP: Policy, planning, coordination & management of disease control programs-NSD	Pregnant & Breastfeeding Women: Not disaggregated	Oversight, technical assistance, and supervision to	Inadequate capacity to manage diagnostic network optimization for VL, EID, and TB, supply chain modernization and laboratory quality management including the fidelity of the lab/inform interface	COP18	COP21	All PEPFAR sites use Mother child cohort registers At least 90% of eligible women of reproductive age and adolescents are on DTG	
USAID	Guidehouse LLP	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Laboratory infrastructure	Inadequate capacity to manage diagnostic network optimization for VL, EID, and TB, supply chain modernization and laboratory quality management including the fidelity of the lab/inform interface	COP18	COP20	Optimization software exercise completed and 100% of recommendations implemented	
USAID	Guidehouse LLP	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	Training in supply chain systems	Inadequate linkage between patient-level facility data and logistics information system for effective management of ARVs and commodities	COP19	COP20	12	
USAID	Guidehouse LLP	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	Supply chain infrastructure	Gaps in surveillance and program data (i.e. data quality and completeness, HI systems) impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels and improve patient-level service delivery and monitoring	COP18	COP20	GoT ownership and oversight of the integrated eIMS- HIM systems	
USAID	Guidehouse LLP	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	Supply chain infrastructure	Gaps in surveillance and program data (i.e. data quality and completeness, HI systems) impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels and improve patient-level service delivery and monitoring	COP18	COP20	100%	
USAID	Guidehouse LLP	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	Supply chain infrastructure	Inefficient systems and resources for import, product registration, clearance, and distribution of commodities under new policy mandates	COP20	COP21	80%	
USAID	Guidehouse LLP	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	Supply chain infrastructure	Inadequate capacity to manage diagnostic network optimization for VL, EID, and TB, supply chain modernization and laboratory quality management including the fidelity of the lab/inform interface	COP18	COP20	65%	
USAID	Guidehouse LLP	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	Supply chain infrastructure	Gaps in surveillance and program data (i.e. data quality and completeness, HI systems) impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels and improve patient-level service delivery and monitoring	COP18	COP20	100% availability	
USAID	Guidehouse LLP	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	Supply chain infrastructure	Inadequate linkage between patient-level facility data and logistics information system for effective management of ARVs and commodities	COP19	COP20	75%	
HHS/CDC	MANAGEMENT AND DEVELOPMENT FOR HEALTH	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Inadequate capacity to manage diagnostic network optimization for VL, EID, and TB, supply chain modernization and laboratory quality management including the fidelity of the lab/inform interface	COP18	COP22	100% of the testing points enrolled on the EQAPIT	
DOD	Henry M. Jackson Foundation For The Advancement Of Military Medicine, Inc., The	ASP: HMS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Research	Slow adoption and implementation of key evidence based policies, guidelines and procedures to facilitate rapid scale up and implementation with fidelity of ART optimization, Viral Load/Early Infant Diagnosis (EID) optimization, HIV self-testing, PEP, TB Preventive Therapy (TPT), Differentiated Care Service Delivery Models (DSDM), Multi Month Dispensing (MMD), use of lay workers, biometric unique identifier and other key strategies across scale up councils and key populations.	COP16	COP21	Data collection on going; Interim results disseminated	
DOD	Henry M. Jackson Foundation For The Advancement Of Military Medicine, Inc., The	ASP: HMS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Research	Slow adoption and implementation of key evidence based policies, guidelines and procedures to facilitate rapid scale up and implementation with fidelity of ART optimization, Viral Load/Early Infant Diagnosis (EID) optimization, HIV self-testing, PEP, TB Preventive Therapy (TPT), Differentiated Care Service Delivery Models (DSDM), Multi Month Dispensing (MMD), use of lay workers, biometric unique identifier and other key strategies across scale up councils and key populations.	COP18	COP21	Data collection on going, this is due to delayed start of data collection as a result of IRB approval timelines	
DOD	Henry M. Jackson Foundation For The Advancement Of Military Medicine, Inc., The	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Inadequate capacity to manage diagnostic network optimization for VL, EID, and TB, supply chain modernization and laboratory quality management including the fidelity of the lab/inform interface	COP18	COP20	100% of newly enrolled HIV testing points (243) participating in the EQAPIT program national wide At least 95% of participating sites passing the 1 Laboratory in Accreditation process	
DOD	Henry M. Jackson Foundation For The Advancement Of Military Medicine, Inc., The	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab accreditation	Inadequate capacity to manage diagnostic network optimization for VL, EID, and TB, supply chain modernization and laboratory quality management including the fidelity of the lab/inform interface	COP19	COP20	1 Laboratory in Accreditation process	
HHS/CDC	World Health Organization	ASP: HMS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMS systems	Gaps in surveillance and program data (i.e. data quality and completeness, HI systems) impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels and improve patient-level service delivery and monitoring	COP20	COP21	Improved country and regional capacity to analyze and link data from and between strengthened, real-time surveillance systems	
HHS/CDC	World Health Organization	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Clinical guidelines, policies for service delivery	Inefficient systems and resources for import, product registration, clearance, and distribution of commodities under new policy mandates	COP18	COP20	National capacity to implement, monitor and report on DTG toxicity	
USAID	TOUCH FOUNDATION, INC.	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	Inefficient system for HCWs prioritization, recruitment, production, allocation, and retention across priority service delivery sites	COP19	COP21	Integration with and utilization of WISN+POA in PORALG LGA level systems=Yes	
HHS/CDC	TANZANIA HEALTH PROMOTION SUPP ORT (THPS)	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Inadequate capacity to manage diagnostic network optimization for VL, EID, and TB, supply chain modernization and laboratory quality management including the fidelity of the lab/inform interface	COP19	COP22	At least 90% of sites providing HRH services implement the RTCOI	
HHS/CDC	MANAGEMENT AND DEVELOPMENT FOR HEALTH	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Training in coordination and management of health systems	Slow adoption and implementation of key evidence based policies, guidelines and procedures to facilitate rapid scale up and implementation with fidelity of ART optimization, Viral Load/Early Infant Diagnosis (EID) optimization, HIV self-testing, PEP, TB Preventive Therapy (TPT), Differentiated Care Service Delivery Models (DSDM), Multi Month Dispensing (MMD), use of lay workers, biometric unique identifier and other key strategies across scale up councils and key populations.	COP20	COP20	300 national ToTs and mentors trained	

APPENDIX D– Minimum Program Requirements

	Minimum Program Requirement	Status	Next steps
Care and Treatment	Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups. ^[1]	Tanzania has adopted a Test & Start policy, and this year Tanzania aligned its Test and Start policy to align with WHO guidance to initiate HIV-positive clients within 7 days.	N/A
	Rapid optimization of ART by offering TLD to all PLHIV weighing >30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens. ^[2]	Circular released Jan 2020 authorizing scale-up of TLD to remaining facilities within the next 8 months. Plans underway for quantification and costing of nevirapine disposal	N/A
	Adoption and implementation of differentiated service delivery models, including six-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents. ^[3]	6MMD started in Dar es Salaam region in February 2020 Established monthly supply chain coordination meetings with clinical and supply chain staff to monitor orders, consumption, and stock.	Remaining scale-up has been proposed to start in April once ARV shipments arrive (end of March)
	All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by end of COP20, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient. ^[4]	Tanzania is on track to complete TPT by end of COP20. Cotrimoxazole is in the clinical care package and on essential medicines list. PEPFAR to purchase pediatric Cotrimoxazole in COP20.	GOT is quantifying need and will raise a case to employ existing exemption policy. Looking into use of 3HP, which will be dependent on availability of fixed dose and price.
	Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	Viral load scale-up remains strong with high lab capacity. EID and VLS TAT 21 days (from sample collection to results return). Established TWG to ensure holistic coordination across lab sector to meet monthly.	Lab TWG to meet monthly to improve coordination starting March 2020.
Case Finding	Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV. ^[5]	Index testing at scale with fidelity. HAPA amendment signed and regulations being finalized. Scale-up in three regions underway. Monitoring plan for index testing among KP put in place in collaboration with CSOs.	KP index testing to resume by April 2020, with continued work to refine the national tools and inclusion of indicators in CLM planned. Expected self-testing operational framework

^[1] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, September 2015

^[2] Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization, July 2019

^[3] Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization, 2016

^[4] Latent Tuberculosis Infection: Updated and consolidated guidelines for programmatic management. Geneva: World Health Organization, 2018

^[5] Guidelines on HIV self-testing and partner notification. Supplement to consolidated guidelines on HIV testing services. Geneva: World Health Organization, 2016 <https://www.who.int/hiv/tub/self-testing/hiv-self-testing-guidelines/en/>

			drafted by WHO in February 2020.
Prevention and OVC	Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices) ^[6]	PrEP endorsed by GOT. Truvada stock interruption will prevent enrollment of new clients until Q3	Preparations for PrEP scale-up (e.g. trainings, demand creation, M&E, systems set up, implementation framework) will start immediately. GOT commitment to convene PrEP TWG before end of March 2020. Scale-up to start immediately when Truvada arrives.
	Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) providing support and case management for vulnerable children and adolescents living with HIV 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	OVC packages have been aligned	Program focus on increasing enrollment of CLHIV and providing prevention services to children aged 9-14
Policy & Public Health systems support	Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention. ^[7]	The government of Tanzania prohibits user fees for all chronic diseases including HIV and TB as well as MCH services in both public and private services. There is no evidence of informal user fees.	N/A
	QUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy. ^[8]	CQI is core component of site-level management and partner workplans. Joint data review and monitoring with GOT using data to drive program improvement is grounded in CQI practices. Tanzania National QI Framework currently being updated, and development of Community QI framework completed in 2019.	N/A
	Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country	Tanzania's Eupha Yanga campaign has been the primary platform to convey messages related to stigma and treatment literacy among the	Campaign resources are insufficient to penetrate all the highest burden districts with messaging.

^[6] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015 (https://www.who.int/docs/default-source/aids-prevention-care-and-treatment/aids-prevention-care-and-treatment-guidelines-2015.pdf?sfvrsn=1_0_0).

^[7] The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care. Geneva: World Health Organization, December 2005.

^[8] Technical Brief: Maintaining and improving Quality of Care within HIV Clinical Services. Geneva: WHO, July 2019.

	leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	general population. The Sitete Reki campaign focuses on reaching youth on the same. Na weza focuses on women of reproductive potential, mothers, and men. The GOT is involved in campaign development and message approval and integrating consistent messages through other channels.	Stigma at the community level. Explore GFATM support
	Clear evidence of agency progress toward local, indigenous partner prime funding.	Tanzania is on track toward its contribution of local, indigenous partner prime funding.	N/A
	Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	The GOT has established an AIDS Trust Fund and is exploring an HIV levy as well as partnerships with private sector entities to channel money to the fund. They have indicated a commitment finance at least 30% of the national HIV response.	
	Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	PEPFAR currently supports implementation of routine death and birth surveillance in multiple regions. Assessment is ongoing to optimize for national scale-up and sustainability.	Limited outcome (i.e. death) available from health facility records. Challenges in establishing cause of death, particularly for community deaths. Continued support for vital registration system strengthening.
	Scale-up of case-based surveillance and unique identifiers for patients across all sites.	Tanzania is planning a national unique identification strategy that includes biometrics and a national health client register. PEPFAR partners will move forward to deploy the unique identification strategy in HIV systems once a GOT system audit has been completed. Tanzania has a national electronic health record for HIV care. Currently, 94% of PLHIV attend clinics currently using the system. The data from this system are currently being utilized by GOT and PEPFAR to jointly achieve the goals of case-base surveillance, monitoring individual level receipt of services and clinical outcomes.	GOT to complete systems audit by June 2020 and roll out to commence immediately after.